EVALUATING COMPREHENSIVE SCHOOL AND COMMUNITY TREATMENT:

Recommendations for strengthening behavioral health services for students with severe emotional disturbance in Montana Schools

INTRODUCTION

In the fall of 2017, based on feedback received from Montana schools, the State Management Team for the federally-funded Project AWARE-MT SOARS grant identified the need to support public school districts to more effectively implement Comprehensive School and Community Treatment (CSCT) programs**.**

To accomplish this goal, the Montana Office of Public Instruction (OPI) hired an independent consultant to conduct an evaluation of current CSCT programs in Montana and develop recommendations and guidance to align CSCT programs with best and evidence-based practices. The consultant was tasked with developing recommendations for how existing and new programs can best operate within the existing CSCT regulatory and billing framework. The following report incorporates insight from more than 300 CSCT and behavioral health experts in both Montana and across the United States in an attempt to more clearly understand the current state of CSCT implementation across Montana and elucidate future directions.

If you have any questions about the contents of this report, contact Katie Loveland MPH, MSW of Loveland Consulting LLC at lovelandk@gmail.com or 406-431-9260.

Loveland
Consulting

METHODOLOGY

This report contains information gathered by an independent consultant about CSCT and other Tier III school-based behavioral interventions. The methods utilized to gather the information for this project include:

- Three electronic surveys targeting (1) CSCT teams (behavioral health aides and mental health professionals), (2) school counselors and psychologists, and (3) school administrators with CSCT experience.
- Semi-structured interviews (13 in total) with local CSCT stakeholders and national school behavioral health and PBIS experts.
- A cross sectional review of CSCT contracts, policies and procedures, referral forms, and program handouts.
- Review of all Administrative Rules of Montana that relate to CSCT.
- Literature review of the evidence-based and school-based behavioral interventions for students with Severe Emotional Disturbance.

The conclusions and recommendations included in this report are solely those of the author and do not nec-essarily represent the views of the Montana Office of Public Instruction or the Project AWARE-MT SOARS State Management Team.
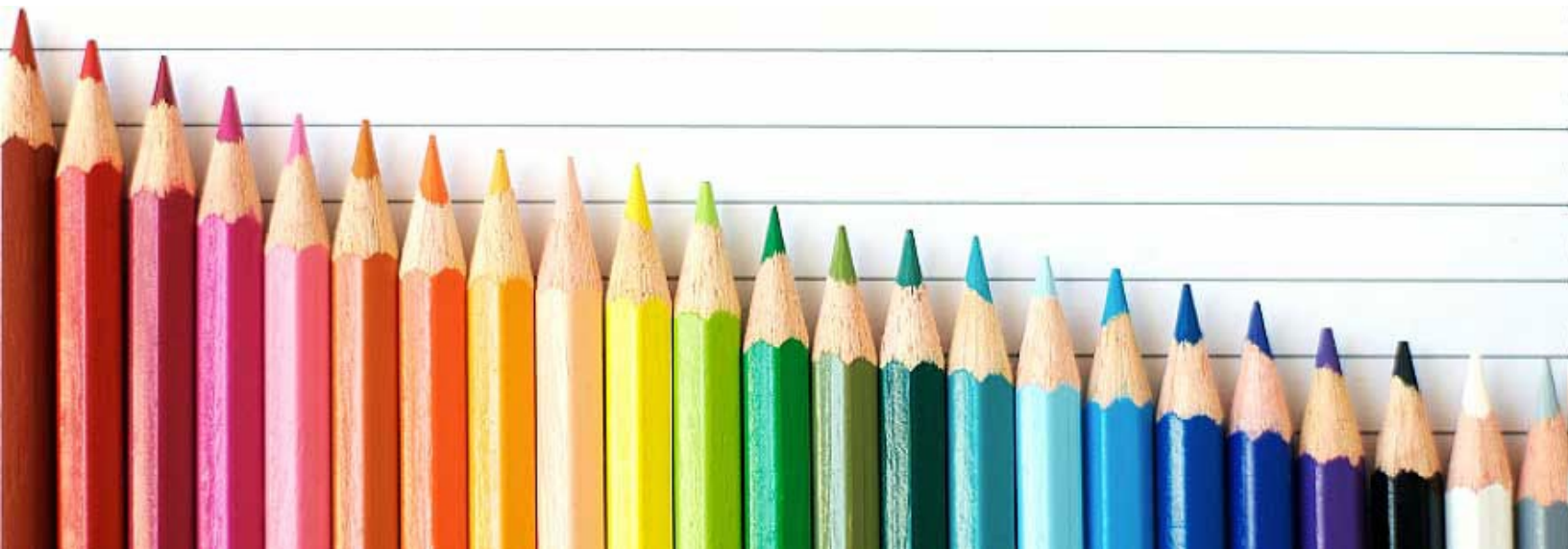

"CSCT PROVIDES EMOTIONAL SUPPORT TO STUDENTS ALONG WITH COORDINATION OF CARE IN SCHOOLS, ALLOWING CLIENTS TO BE MORE SUCCESSFUL AND ATTEND CLASSES."
Montana School Administrator

PART ONE

Assessing the Current State of CSCT Implementation in Montana

WHAT IS CSCT?

OVERVIEW

The Comprehensive School and Community Treatment (CSCT) program is a school-based behavioral health service for children with Serious Emotional Disturbance (SED) supported by the Children's Mental Health Bureau at the Montana Department of Public Health and Human Services (DPHHS). Pursuant of Montana Administrative Rule, CSCT allows accredited public school districts to contract with mental health centers to provide behavioral health services to children with SED using a CSCT team. These behavioral health services can be billed to Medicaid under the school's Medicaid provider number. Schools can also choose to provide these behavioral health services directly, although districts in Montana almost exclusively contract with mental health centers for CSCT services. CSCT teams include a licensed or in-training mental health practitioner and behavioral specialist/aide who provide services in the school under the supervision of an employee or contractor of the mental health center.
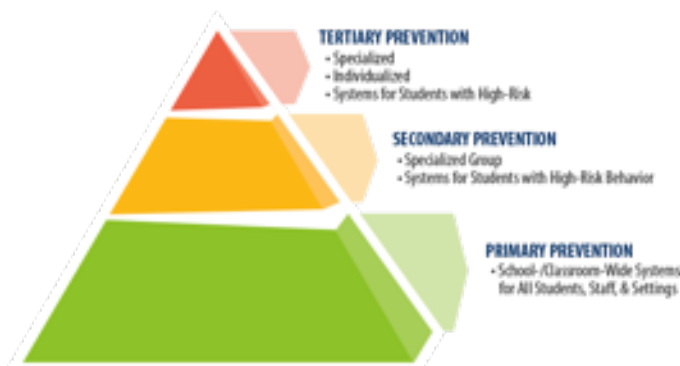
Established in 2005, CSCT is the primary vehicle through which Medicaid services are delivered in Montana schools, accounting for over 80 percent of all school-based Medicaid services and serving around 5,100 students per year. The total federal budget for CSCT Medicaid services is approximately $34 million per year. Adding in the match provided by CSCT schools, the program's total budget is roughly $52 million annually.

CSCT AND MBI

CSCT is designed to be a Tier III Service within the Montana Behavioral Initiative (MBI) structure (known nationally as Multi-Tiered Systems of Support (MTSS) or School Wide Positive Behavioral Interventions and Supports (PBIS)). MBI is a framework for establishing a learning environment that supports social, emotional, behavioral, and academic success for all students. MBI is Montana's state-level initiative to implement PBIS/MTSS, providing ongoing support for schools implementing behavioral supports for all students.

In the MBI model, supports are provided to all students at varying levels of intensity tailored to the student's unique behavioral health needs. In Tier I, all students and staff are provided school-wide primary prevention supports that create clear expectations and support a positive school culture. For students that exhibit behavioral concerns and require additional supports, MBI schools provide Tier II interventions for secondary prevention that may include rapid response and preventative behavioral interventions implemented by teachers in the classroom or structured group or individual interventions utilizing school counselors or other staff. Approximately 20 percent of all students in a building may require Tier II support.

High risk, high needs students who do not respond to Tier II interventions are referred to Tier III where they are provided individualized, higher intensity interventions. CSCT is designed to be a Tier III intervention for children in Montana schools who are in crisis or meet the criteria for SED. It is estimated that approximately 5 percent of students in any given population will require these services. Currently, Montana is the only state in the nation that reimburses for Tier III services through Medicaid, making CSCT a unique program designed to allow MBI to be fully operational in Montana schools.

TERTIARY PREVENTION
- Specialized
- Individualized
- Systems for Students with High-Risk

SECONDARY PREVENTION
- Specialized Group
- Systems for Students with High-Risk Behavior

PRIMARY PREVENTION
- School-/Classroom-Wide Systems for All Students, Staff, & Settings

ELIGIBILITY

As stated previously, students receiving CSCT services must meet criteria for SED and functional impairment.[1] According to Montana Administrative Rule, CSCT programs can serve all clients from 3 to 20 years of age who are attending an accredited public school served by CSCT. CSCT programs must provide services to all students who qualify, not just students eligible for Medicaid, billing all available financial resources to support the CSCT services, including private third party payers. Schools may utilize a sliding fee schedule for families without health insurance. Students admitted into CSCT programs with a SED diagnosis may receive CSCT services at school, in their homes, or in the community, although the majority of CSCT services are provided in schools.

Medicaid-eligible youth not meeting the SED criteria but experiencing a behavioral health crisis or express acute need may be referred to CSCT for brief intervention, assessment, and referral for up to 20 units of service annually. After 20 units of service, youth receiving CSCT services must receive a full clinical assessment indicating that that they meet SED criteria. CSCT services can be provided to students without an Individualized Education Plan (IEP), a unique feature of the CSCT program compared to all other school-based healthcare services in Montana.

BILLING CODES

CSCT programs can bill up to 720 units of service per month per team to the Montana Medicaid program and up to 28 units a day for a single client. Claims above 28 units per day per client will be suspended for review by the Children's Mental Health Bureau and require documentation to determine medical necessity. CSCT programs operating in Montana utilize the following billing codes to receive reimbursement from Medicaid.

CODE	REIMBURSABLE SERVICES	TARGET POPULATION	MAXIMUM UNITS
H2027	Assessment, intervention, and referral services	Non-SED youth	20 during any fiscal year, July 1 to June 30
H0036	Treatment and behavioral intervention/redirection: face-to-face per 15 minutes (minimum 8 minutes for one 15-minute unit). Include individual, family (with or without the youth, as directed by the Individual Treatment Plan), and group counseling.	Youth with SED	Up to 720 team units per month

NON-REIMBURSABLE SERVICES AND SERVICE DOCUMENTATION

The following services are not reimbursable under the CSCT program.

- Time for documentation, including notation and report writing.

- Observation and monitoring.

- Services that are not provided face-to-face.

- Meetings.

- Educational/academic assistance with school work.

RELEVANT ADMINISTRATIVE RULES

CSCT programs operate under the following Administrative Rules of Montana that dictate how CSCT programs are defined and structured along with what services can be billed.

*Note: Administrative Rules of Montana (ARM) are subject to change, and the full wording of the ARM that govern CSCT is not included in this document. Always consult the most updated ARM on the [Montana Secretary of State's website](#) before making decisions related to billing or program design.

TOPIC	ARM	SUMMARY OF ARM SPECIFICATIONS*
Program definitions and	37.106.1902	CSCT means "a comprehensive, planned course of community mental health outpa-tient treatment provided in cooperation and under written contract with the school district where the youth attends school."
endorsements	37.87.1803	CSCT services must be delivered by a licensed mental health center and billed under the school district's provider number.
	37.106.1955	Licensed mental health centers providing CSCT must have a CSCT endorsement issued by the department showing that they: • Have written admission and discharge criteria. • Have a written contract with the school district in accordance with ARM 37.87.1802.
Billing	37.87.1803	Mental health services provided concurrently with CSCT are billed under the mental health center's provider number. Outpatient therapy codes may not be billed to Medicaid by CSCT concurrent with CSCT claims. One CSCT team with two full-time employees can be reimbursed up to 720 billing units per team per month. Services must be billed for the month the service is provided. The mental health professional must provide at least 40 percent of the units billed by the team each month. Billing units are calculated based on the sum total of minutes each professional spent with the youth per day. Up to 20 CSCT units per youth (without an assessment or SED diagnosis) per state fiscal year may be billed for an intervention, assessment, and, if necessary, referral to other services. There is no limit to the number of youth who may be served. For a youth to qualify for more than 20 units of CSCT, a full clinical assessment is required and the youth must meet SED criteria. As Medicaid providers utilizing CSCT, schools must: • Bill all available financial resources for support services, including third party insurance and parent payments. The district may use a sliding fee schedule. • Document services to support the Medicaid reimbursement received. The school district must meet the certification of match requirements and provide DPHHS a copy of the certification of match documentation annually. Failure to meet reporting requirements may result in suspension or termination of CSCT services or programming for the following school year.

RELEVANT ADMINISTRATIVE RULES CONTINUED

TOPIC	ARM	SUMMARY OF SPECIFICATIONS* CSCT
Client population	37.87.1803	CSCT services may be provided to: • Children aged 3-5 receiving special education services from a public school with an IEP or attending a preschool offered through a public school. • Youth aged 6-20 who are enrolled in a public school.
CSCT Services	37.106.1956	CSCT programs must be able to provide: • Individual, group, and family therapy. • Behavioral intervention. • Other evidence and research-based practices effective in the treatment of youth with SED. • Direct crisis intervention services when the student is in school (or school-operated facility). • A crisis plan that includes face-to-face encounters and telephonic, 24/7 responses. • Treatment plan coordination with substance use and mental health services outside of CSCT. • Access to emergency services. • Referral and aftercare coordination with inpatient and residential treatment facilities.

Staffing and supervision	37.106.1956	CSCT must employ sufficiently qualified staff to deliver all CSCT services to youth as outlined in the Individual Treatment Plan (ITP) for the youth and in accordance with the contract between the school and mental health center.
		
		Staff must include a:
		• Full-time equivalent licensed or in-training mental health professional. In-training mental health professionals must be supervised by a licensed mental health professional and must be licensed by the last day of the calendar year following the state fiscal year that supervised hours are completed.
		• Full-time equivalent behavioral health aide working under the clinical oversight of a licensed mental health professional. Behavioral health aides must have:
		  o A high school diploma or GED equivalent.
		  o At least two years experience working with emotionally disturbed youth, providing direct services in a human services field or post-secondary education in human services.
		• An employed or contracted supervisor who has "daily, overall responsibility for the CSCT program". The supervisor must:
		  o Be knowledgeable about the mental health service and support needs of youth.
		  o Meet with an appropriate school district representative at least every 90 days to mutually assess program effectiveness including progress on ITP, attendance, CSCT program referrals, contact with law enforcement, referral to a higher level of care, and discharges from the program.
		  o May provide direct CSCT services in the absence of staff for no more than three months.

RELEVANT ADMINISTRATIVE RULES CONTINUED

TOPIC	ARM	SUMMARY OF ARM SPECIFICATIONS*
Contract Requirements	37.87.1802	The licensed mental health center providing CSCT services must have a written contract with the school district. The contract must identify all schools in which CSCT will be provided, including:

The licensed mental health center providing CSCT services must have a written contract with the school district. The contract must identify all schools in which CSCT will be provided, including:

- Specific services to be provided.
- Staffing by position and minimum qualifications.
- Description of the mental health services provided by the mental health center during and outside of normal classroom hours.

In the contract, the school must identify the following logistical supports.

- Provision of transportation and classroom space during nonschool days as described in ARM 106.1956.
- The role of the school counselor and school psychologist in coordinating with CSCT and providing mental health services.
- Program supports, including telephone, computer access, locking file cabinets, and copying that the school will make available for CSCT staff.
- Office space that is adequate and appropriate for confidentiality and privacy.
- Treatment space large enough to host a group during both school and nonschool days.

In the contract, the school and mental health center must identify:

- A referral process for CSCT.
- An enrollment process that includes the CSCT licensed or in-training mental health professional and a school administrator or designee to ensure youth have access to services prioritized to acuity and need, and considers the current CSCT wait-list.

In the contract, the school must describe the implementation of school-wide PBIS, including, at minimum:

- Identifying youth who exhibit inappropriate behaviors and need a PBIS plan and youth at risk of, or suspected to have need of, mental health services.
- Implementing and monitoring the progress of a PBIS plan for effectiveness.
- Referring youth to the CSCT program when PBIS have not resulted in behavior change and when the youth may have a clinical condition that needs to be addressed.

In the contract, the school and mental health center must describe the annual training offered to school personnel, parents, and students related to:

- CSCT programs and services.
- CSCT referral process and criteria.
- Signs and symptoms that indicate a need for mental health services.
- Confidentiality requirements under the Family Education Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and the Privacy and Security and the Health Information Technology for Economic and Clinical Health Act (HITECH).

The contract should identify program data and information that will be shared between the school and mental health center to evaluate program effectiveness. The contract must include record keeping, management, billing procedures ,and must state which party is responsible for each requirement. If a school district is the mental health center providing a CSCT program, the school district must adopt an operational plan that is substantially similar to these contractual requirements and must keep the operational plan on file.

RELEVANT ADMINISTRATIVE RULES CONTINUED

TOPIC	ARM	SUMMARY OF ARM SPECIFICATIONS*
Summer Services	37.106.1956	CSCT services must be available 12 months of the year with a minimum of 16 hours per month during the summer months.
Individualized Treatment Plan	37.106.1956	CSCT treatment must be provided according to an ITP designed by a licensed or in-training mental health professional who is a CSCT staff member.
	37.106.1916	The client's parent/legal guardian/representative must sign and date the ITP, indicating participation in its development. The plan must include, among other things: - Measurable treatment plan objectives. - The treatment team members involved in the client's care. - A description of the service or intervention to be provided and demonstrate the relationship between the service or intervention and state objectives. - Criteria for discharge. ITPs must be reviewed at least every 90 days for each client. Treatment plan reviews must be comprehensive, addressing the client's response to treatment and result in either an amended plan or a statement of the continued appropriateness of the current plan. The plan must document the client's functioning and justification for each client goal.
ITP team	37.106.1956	The team that creates the CSCT ITPs must include: - Licensed or in-training mental health professional. - School administrator or designee. - Parent(s) or legal representative/guardian. - Youth, as appropriate. - Other person(s) who are providing services or who have knowledge or special expertise regarding the youth.
Communication and Coordination	37.106.1956	Providers must inform the youth and their parent/legal representative/guardian that Medicaid requires coordi-nation of CSCT with home support and outpatient therapy, when applicable.
	37.87.1404 37.106.1965	CSCT programs must be "coordinated with the special education program of the youth" if the youth is receiving special education services. At least one CSCT team member must attend the IEP meeting when requested by the parents/legal representative/guardian or the school.
Training and Orientation	37.106.1960	The CSCT program must be delivered by adequately trained staff receiving competency-based training that is documented and maintained in personnel files. Staff are required to receive 18 hours of training per year in behavior management strategies that focus on the prevention of behavior problems for youth with SED. Training must include: - Positive behavioral intervention planning and support. - Classroom and youth behavior management techniques that include certified de-escalation training inclusive of physical and non-physical methods. - Evidence and research-based behavior interventions and practices. - Progress monitoring techniques to inform treatment decisions.

RELEVANT ADMINISTRATIVE RULES CONTINUED

TOPIC	ARM	SUMMARY OF ARM SPECIFICATIONS*
Training and Orientation continued	37.106.1960	All CSCT staff must receive a minimum of 18 hours of training during their first three months of employment. Orientation should address: • Certified de-escalation training inclusive of physical and nonphysical methods. • Child development. • Behavior management. • Crisis planning. • Roles and responsibility of CSCT staff in the school setting. • School culture. • Confidentiality requirements. • Staff and program supervision. • CSCT program procedures.
Waiting List	37.87.1801	Youth referred to the program must be served in sequential order as determined by the priorities based on acuity and need regardless of payer. • Risk of self-harm or harm to others. • Needs support transitioning from intensive out-of-home or community-based services. • Meets SED criteria. • Not responding to PBIS. • Not attending school due to the mental health condition of the youth.

Record Requirements	37.106.1961	CSCT must maintain the following records for clients.
		• Written referral cosigned by the parent/legal representative/guardian documenting the reason for referral.
		• Signed verification indicating the parent has been informed that Medicaid requires coordination between CSCT, home support services, and outpatient therapy.
		• Copy of the clinical assessment documenting the presence of SED.
		• CSCT ITP.
		• Daily progress notes from each team member documenting individual therapy sessions and other direct services provided, including:
		    o When therapy or therapeutic intervention begins and ends.
		    o Total number of minutes spent each day with the youth.
		    o Ninety-day treatment plan reviews.
		    o Discharge plan.
		• Required clinical records required of all mental health centers in ARM 37.85.414 in addition to the above records include records for youth referred to CSCT and denied acceptance into the program, including their written referral and documentation detailing the reason for the denial.

EVALUATING THE CURRENT STATE OF CSCT IMPLEMENTATION

The previous section outlines the broad array of rules that govern CSCT in Montana. Because the program involves individual contracts between hundreds of school districts and mental health center providers and, because of the complexity of administrative rules that govern the program, there is wide variation in program implementation across the state. The following data summarize findings of an evaluation designed to assess the current state of CSCT implementation and fidelity to the original program design as outlined in the governing ARM.

SURVEY RESULTS

■ METHODOLGY

On October 24, 2017 ,electronic surveys were sent to three different groups of CSCT stakeholders across Montana from a list of schools currently implementing the program provided by the OPI. Three different survey instruments were designed for:

- CSCT teams, including licensed and unlicensed therapists and mental health/behavioral health aides.
- School administrators, including superintendents and school principals, in schools implementing CSCT.
- School counselors and psychologists in schools implementing CSCT.

Electronic survey links were sent to building-level school administrators who were asked to forward the appropriate links to their CSCT teams and school counseling/psychology staff. The CSCT team survey was also distributed through the CSCT Coalition, whose members were asked to forward it to their affiliated CSCT team members.

The CSCT team survey received 190 responses, the CSCT school administrators survey received 79 responses and the school counselor/psychologist survey received 45 responses. The following pages summarize the key findings from the survey as analyzed in aggregate by an independent consultant.

RESPONDENT TYPE

What is your role on the CSCT team?
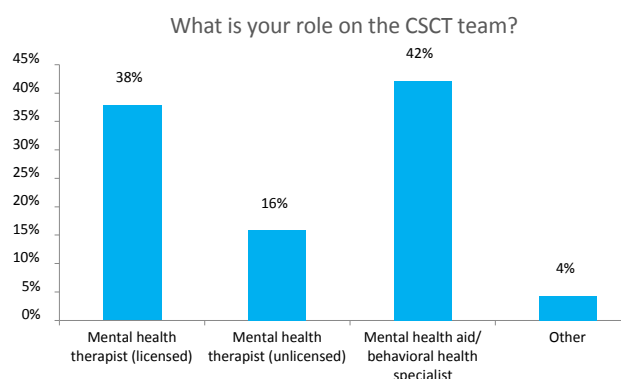
The responses summarized here represent the views of a wide range of CSCT stakeholders who implement or interface with the program. Survey responses were received from a range of CSCT stakeholders and s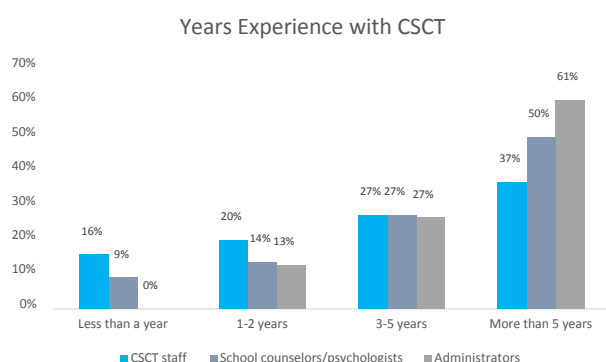taff. Fifty-four percent of the CSCT team survey respondents were either licensed or unlicensed therapists and 42 percent were mental health aides or behavioral health specialists. More than two-thirds of respondents to the school counselor/ psychologist survey were school counselors followed by 20 percent who identified as school psychologists. Three out of four of the respondents to the school administrators survey were principals, followed by superintendents (11 percent) and vice principals (8 percent).

What is your role as a school-based behavioral health provider?

What is your role in school administration?
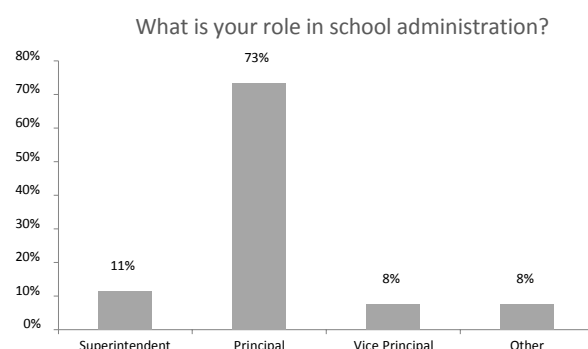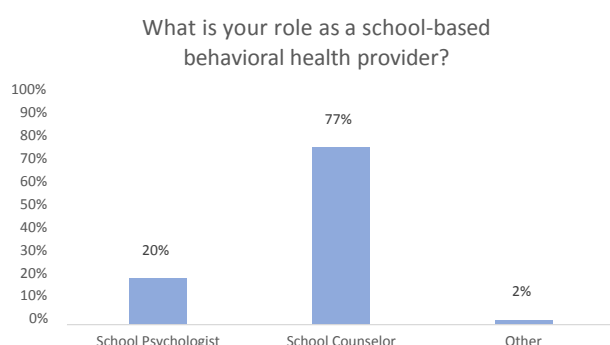
YEARS EXPERIENCE WITH CSCT AND MENTAL HEALTH

Years Experience with CSCT

CSCT Team: How long have you worked in the field of behavioral health?

The majority of school administrators and school counselors/ psychologists indicate that they have more than five years experience with CSCT. In contrast, CSCT team members indicate less experience overall with the program, with 36 percent reporting two years or less experience with CSCT and 37 percent reporting more than five years experience. These findings mirror much of the qualitative data gathered from interviews where stakeholders expressed concerns about retention and turnover of CSCT staff because of low wages and job stress.
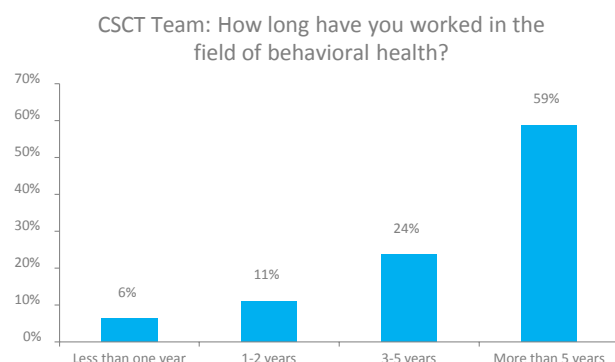
Although the majority of CSCT team members report fewer than five years experience with the program, more than half (59 percent) indicate more than five years experience with mental or behavioral health in general. Thus, many CSCT team members currently working in schools often bring a wealth of experience with mental and behavioral health to their jobs, even if their longevity with the CSCT program is limited.

■ POPULATIONS SERVED

Age of students served in CSCT program

	CSCT staff	School counselors/psychologists	Administrators
High school	21	29	23
Middle school	30	22	23
Elementary	49	49	54

■ Elementary ■ Middle school ■ High school

Elementary school students were the most common age group served by the survey respondents. Approximately 50 percent of the respondents indicated serving this age group through their CSCT program with the other 50 percent fairly evenly split between middle and high school. Some respondents reported serving multiple age groups through their programs.

The majority of CSCT programs are being implemented in larger schools. CSCT programs being implemented in communities with Class AA or A 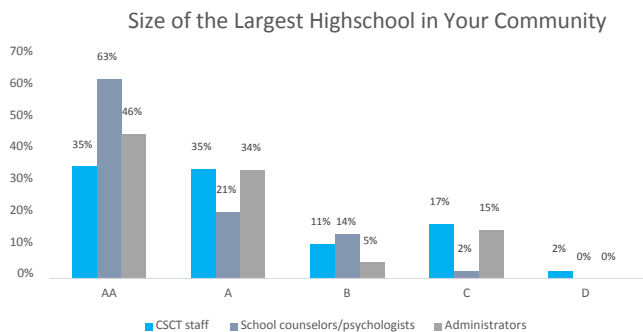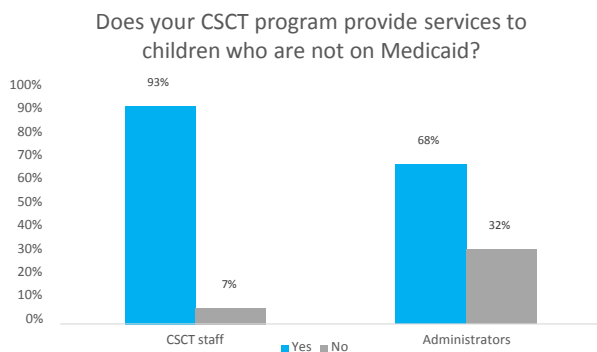high schools comprise 70 percent or more of all respondents across the three survey groups. Schools that have school counselors/psychologists and CSCT programs seem particularly concentrated in Class AA or A schools, with 84 percent of the school counselor/psychologist CSCT survey respondents indicating they serve in a community with a AA or A high school. Less than 20 percent of responses to the surveys came from communities with a Class C high school and 2 percent or fewer were in communities with a Class D high school.

Size of the Largest Highschool in Your Community

	AA	A	B	C	D
CSCT staff	35%	35%	11%	17%	2%
School counselors/psychologists	63%	21%	14%	2%	0%
Administrators	46%	34%	5%	15%	0%

■ CSCT staff ■ School counselors/psychologists ■ Administrators

■ PAYMENT

Does your CSCT program provide services to children who are not on Medicaid?

	CSCT staff	Administrators
Yes	93%	68%
No	7%	32%

■ Yes ■ No

The administrative rules governing CSCT programs require that schools provide services to students regardless of their insurance status. However, some CSCT programs indicate that they only or primarily serve Medicaid clients. CSCT teams are much more likely than school administrators to indicate that their CSCT program serves students who do not have Medicaid. More than 9 in 10 CSCT staff indicate their program accepts non-Medicaid clients while about 2 in 3 administrators indicate this.

Responses to an open-ended question in the survey asking schools to describe CSCT payment provide insight into the challenges schools face related to billing for CSCT services. Often, survey respondents indicated that their CSCT programs do offer services to students with insurance types other than Medicaid or to students without insurance, but many families offered these services do not accept it because of the cost of co-pays, sliding fee schedules, or other barriers. One CSCT team member noted, "Self-pay is an option, however it is very rare due to the cost of services." Another said, "I have, in eight years, never seen non-Medicaid clients. The co-pay for Blue Cross Blue Shield would be $40/visit or $200/week." Many survey respondents felt that the program is essentially designed for Medicaid clients, so enrolling students who are not covered under the program presents a challenge. "It's difficult and complicated to enroll and bill for students who are not on Medicaid. The program setup almost implicitly discourages enrollment of non-Medicaid students. For programs with unlicensed therapists, it feels almost impossible." Billing for services and engaging clients who are not on Medicaid is a challenge for many CSCT programs, even if, on paper, they offer CSCT services to all students, regardless of payer.

■ USE OF MBI/PBIS

The CSCT administrative rules also state that schools with CSCT contracts should be implementing Positive Behavioral Interventions and Supports (PBIS aka MBI), a school wide multi-tiered system of supports that incorporates CSCT as a Tier III intervention for students in crisis or with SED who need individualized, targeted behavioral support beyond the services provided at Tiers I and II. Most CSCT stakeholders indicate that their school does implement MBI alongside CSCT; however, between 15 and 22 percent of respondents indicate that their school does not implement MBI.

As with the payment question, respondents who answered yes to the "does your school implement MBI" question were encouraged to further explain the relationship between their school and MBI. Their responses show a wide variation in the way MBI and CSCT interact in local schools.

A subset of respondents reported that, although their school has an MBI program, it is not integrated with CSCT in any way. "We do not interact in any formal or active manner," noted one CSCT team member. Another reports, "There is little contact between MBI and CSCT staff. This would be an improvement if MBI would utilize the CSCT staff more."

Another group of respondents note that their school conceives of MBI primarily as a Tier I intervention that sets school-wide behavioral expectations that are reinforced by CSCT. One school administrator noted that CSCT and MBI in his building "don't cross paths much. The CSCT program utilizes our universal expectations for the school and reinforces them with the students they work with." Another administrator explains, "We participate in the school-wide reward system and are asked to give feedback on MBI implementation."

Despite the minimal interaction of MBI and CSCT reported by some schools, others report that CSCT is understood as a Tier III Intervention that is utilized as part of the broader continuum of tiered supports being implemented school-wide through MBI. One school staff member describes their MTSS system this way. "We have Tier I interventions such as phone calls home to a parent, one-on-one with a child, and team meetings with the child to address the behavior. If those Tier I interventions don't work,

Does your school implement MBI?
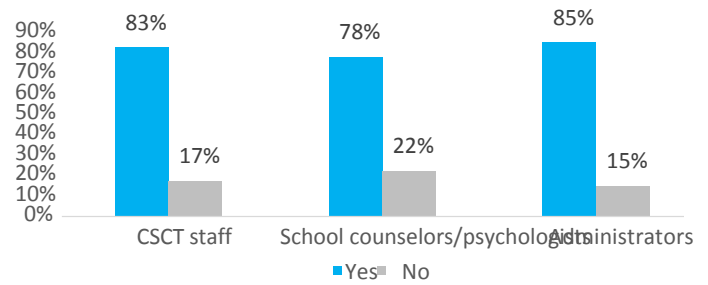
then Tier II interventions would be implemented, such as 2X10, check in/check out, and SAT team behavioral meetings. If Tier I and Tier II aren't successful, then the child would be referred to CSCT."

Schools with CSCT and MBI processes that are most integrated often report having an ongoing, active problem-solving teams. One administrator described how his school "implemented a student assistance team designed to respond to student needs, mostly behavioral. After a student has received supports from the student assistance team and the team has tried Tier I and II interventions, the next step is other referrals if the student needs more. At that point a referral to CSCT might be made." It is clear from the responses from schools where MBI and CSCT are well coordinated that successful problem-solving teams have regular meetings attended by both CSCT staff and key school staff members to facilitate ongoing communication and coordination.

Why are CSCT and MBI not well coordinated in all schools? This is a question that might merit more in-depth study, but, from what can be ascertained from these survey responses, it appears that there is a lack of understanding in many schools about the scope of MBI as a school-wide MTSS in which CSCT is embedded at the Tier III level. Several schools also underscored, as a barrier to integration, administrative concerns about confidentiality. One CSCT team member said this of the MBI problem-solving team in her school: "They do not invite me to meetings because the principal said I would learn about kids who are not in my care and that would be a breach of confidentiality." More work could be done to help school better understand and integrate MBI and CSCT.

RATING PROGRAMMATIC ASPECTS OF THE CSCT PROGRAM

Survey respondents were asked to rate various aspects of their school's CSCT program as excellent, good, fair, or poor.   Below is a summary of their responses. School counselors/psychologists were not asked to rate all program areas.

■ **COMMUNCIATION AND COORDINATION**

CSCT Program Rating: Communication and coordination with teachers

	CSCT Team	School administrators
Excellent	43%	43%
Good	51%	43%
Fair	6%	10%

Legend: Poor, Fair, Good, Excellent

CSCT Program Rating: Communication and coordination with school administration

	CSCT Team	School Administrators
Excellent	53%	54%
Good	36%	32%
Fair	10%	9%

Legend: Poor, Fair, Good, Excellent

CSCT Program Rating: Communication and coordination with school counselors/psychologists

	CSCT Team	School Administrators	School Counselors/Psychologists
Excellent	53%	47%	56%
Good	34%	40%	32%
Fair	11%	9%	12%

Legend: Poor, Fair, Good, Excellent

CSCT program rating: Communication and coordination with CSCT students and families

	CSCT Team	School Administrators	School Counselors/Psychologogists
Excellent	40%	43%	66%
Good	53%	49%	28%
Fair	6%	4%	6%

Legend: Poor, Fair, Good, Excellent
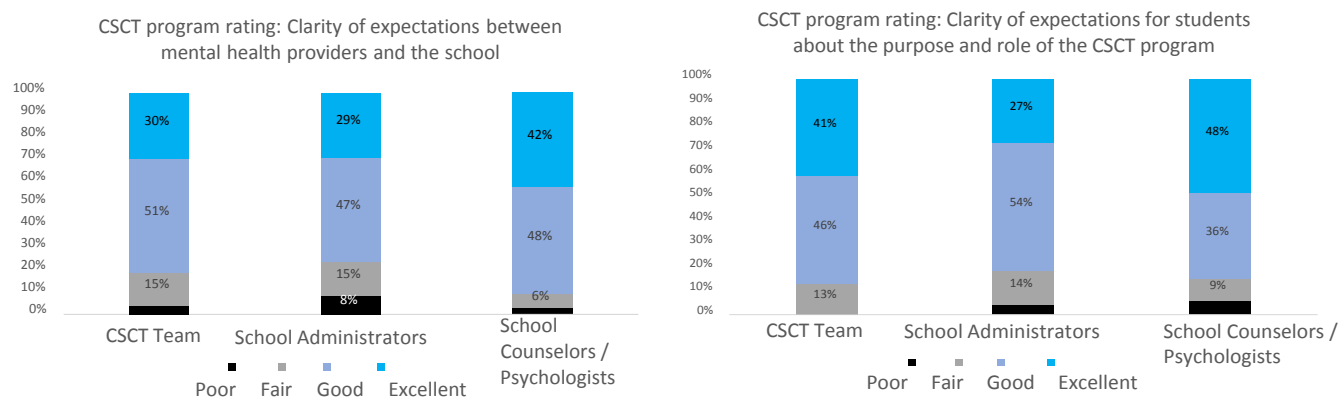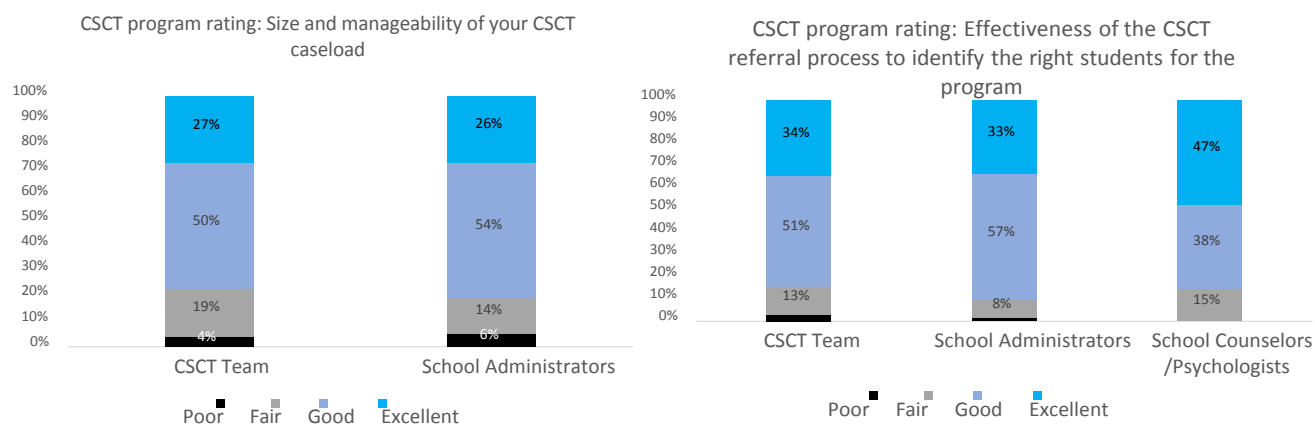
The CSCT stakeholders generally rated the various aspects of communication for the program as excellent or good. Communication with school administration and school counselors/psychologists was more likely to be rated excellent than communication with teachers and/or CSCT students and families.

◼ CLARITY OF EXPECTATIONS

Clarity of program expectations between mental health providers and the school and for students was less likely to be rated excellent and more likely to be rated fair or poor than the communication and coordination aspects for the program. Less than a third of CSCT team members and school administrators rated "clarity of expectations between mental health providers and the school" as excellent and less than half of all respondents rated the "clarity of expectations for students about the role and purpose of CSCT" as excellent. Clarity of expectations is one area that could be improved in many schools.

CSCT program rating: Clarity of expectations between mental health providers and the school

CSCT program rating: Clarity of expectations for students about the purpose and role of the CSCT program

◼ CASELOAD AND REFERRALS

CSCT program rating: Size and manageability of your CSCT caseload

CSCT program rating: Effectiveness of the CSCT referral process to identify the right students for the program

The size and manageability of caseloads was one of the lowest rated aspects of the CSCT program. Just over 25 percent of CSCT team members and school administrators rate the size and manageability of their CSCT caseload as excellent and about one in five rated their caseload as poor or fair. Around a third of CSCT team members and administrators rated the effectiveness of their referral process as excellent, with almost half of school counselors/psychologists in agreement. Concerns about caseloads and referrals were echoed in semi-structured interviews and open-ended survey comments, which are summarized below.

◼ TREATMENT/EDUCATIONAL PLANNING AND COORDINATION

CSCT program rating: Creation of effective Individual Treatment Plans
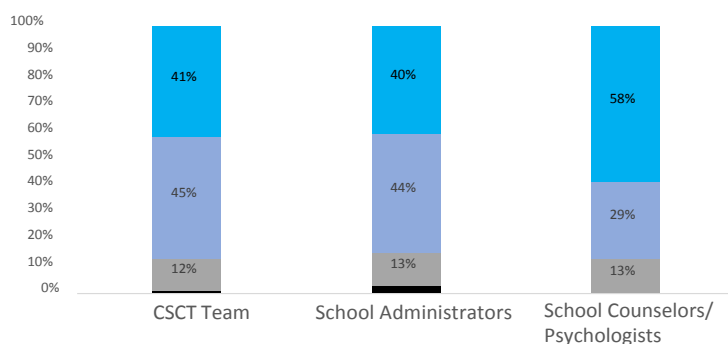
|	CSCT Team	School Administrators	School Counselors Psychologists
Excellent	43%	25%	25%
Good	53%	56%	56%
Fair		15%	15%
Poor	4%		
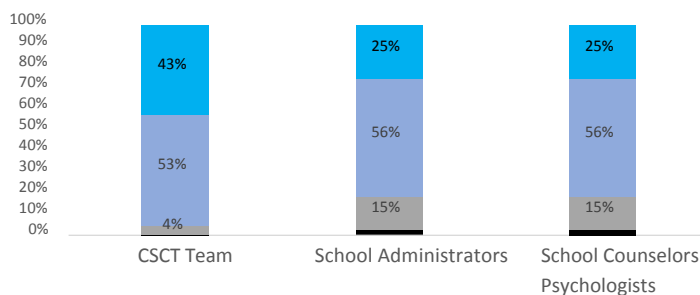
CSCT program staff are more likely than school administrators or counselor/psychologists to rate "the creation of effective Individual Treatment Plans" as excellent. School administrators and counselors/ psychologists were much more likely to rate the "coordination with student's Individual Education Plans and special education teams" as excellent compared to the Individual Treatment Plan rating. In terms of "coordination with student's home support services and outpatient therapy" less than one in five CSCT members and one in four school administrators rated this measure as excellent and almost a third rated it fair or poor making this one of the lowest rated program aspects assessed. This is concerning as coordination with home support and outpatient therapy is a required aspect of CSCT programs as outlined in the ARM.

CSCT program rating: Coordination with student's Individualized Education Plans and special education teams

	CSCT Team	School Administrators	School Counselors/ Psychologists
Excellent	41%	40%	58%
Good	45%	44%	29%
Fair	12%	13%	13%

CSCT program rating: Coordination with CSCT student's home support services and outpatient therapy, when necessary

	CSCT Team	School Administrators
Excellent	19%	27%
Good	50%	58%
Fair	27%	11%
Poor		

■ Poor ■ Fair ■ Good ■ Excellent
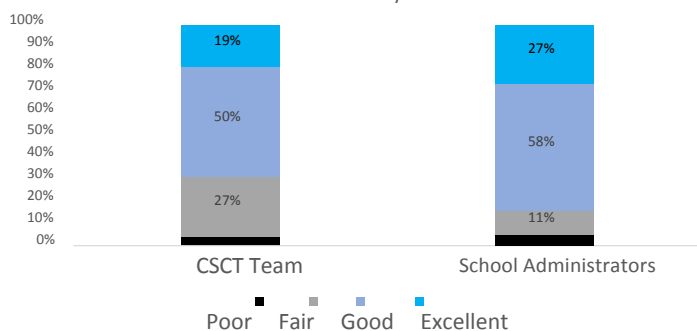
◼ TRAINING AND ACCESS TO SUPPORT

CSCT program rating: Access to training to support CSCT and school staff

	CSCT Team	School Administrators
Excellent	34%	22%
Good	41%	45%
Fair	18%	24%
Poor		
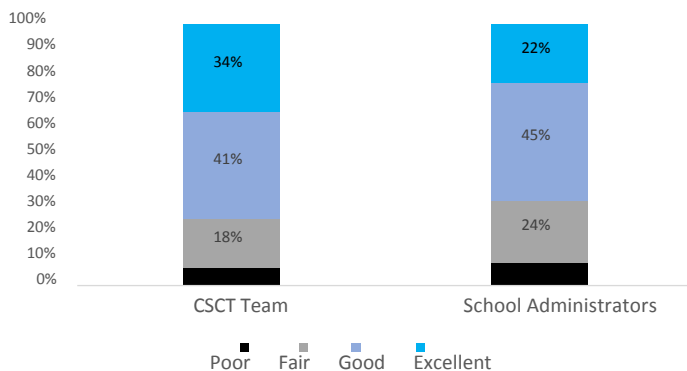
More than one in four CSCT team members and administrators rate "access to training and support for CSCT and school staff" as fair or poor. The need for more comprehensive training on CSCT, MBI, and classroom management was echoed in many key informant interviews and opened ended survey responses (see below).

■ Poor ■ Fair ■ Good ■ Excellent

■ USE OF EVIDENCE-BASED AND TRAUMA-INFORMED PRACTICES

CSCT program rating: Use of evidence-based practices

	CSCT Team	School Administrators	School Counselor/Psychologists
Excellent	42%	24%	42%
Good	51%	57%	50%
Fair			
Poor	5%	13%	4%

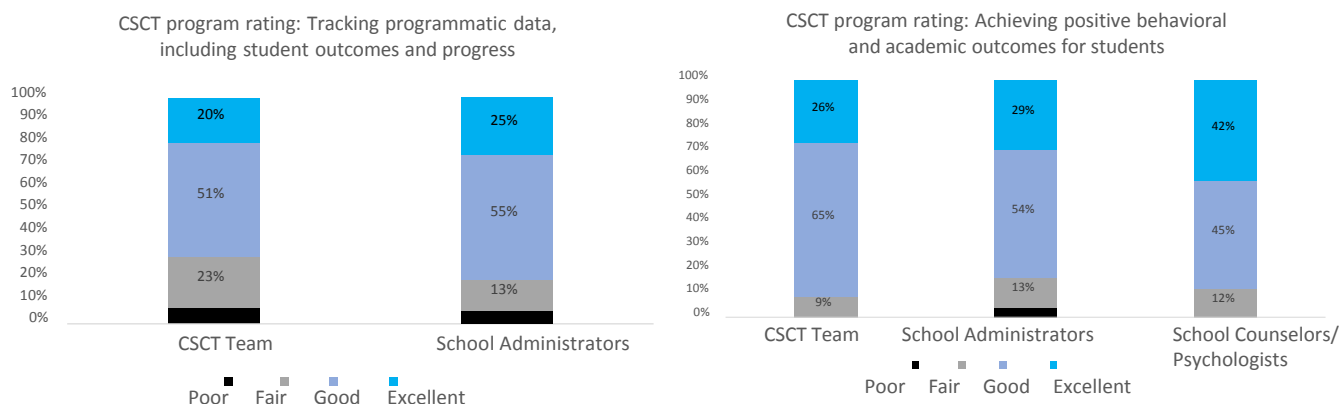Poor ■ Fair ■ Good ■ Excellent ■

CSCT program rating: Use of trauma informed practices

	CSCT Team	School Administrators	School Counselors/Psychologists
Excellent	45%	24%	39%
Good	49%	57%	50%
Fair			
Poor	4%	13%	5%

Poor ■ Fair ■ Good ■ Excellent ■
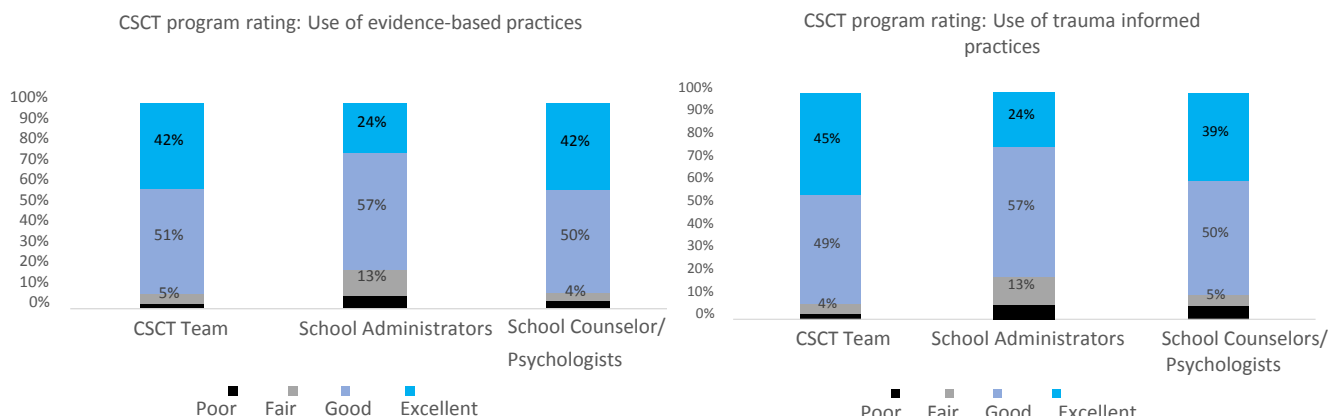
The majority of CSCT team members indicate that their use of evidence-based and trauma-informed practices is excellent or good. School administrators were less likely to rate the use of evidence-based and trauma-informed practices as excellent compared to CSCT team members and school counselors/psychologists. This discrepancy may arise from a lack of knowledge among school administrators about evidence-based behavioral health interventions and trauma-informed practices.
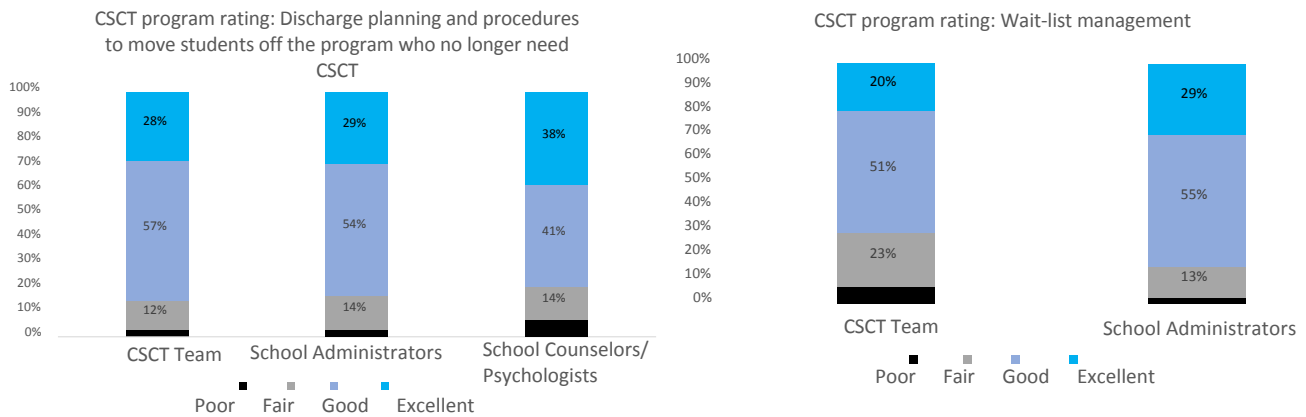
■ TRACKING AND ACHIEVING OUTCOMES

CSCT program rating: Tracking programmatic data, including student outcomes and progress

	CSCT Team	School Administrators
Excellent	20%	25%
Good	51%	55%
Fair	23%	13%
Poor		

Poor ■ Fair ■ Good ■ Excellent ■

CSCT program rating: Achieving positive behavioral and academic outcomes for students

	CSCT Team	School Administrators	School Counselors/Psychologists
Excellent	26%	29%	42%
Good	65%	54%	45%
Fair	9%	13%	12%
Poor			

Poor ■ Fair ■ Good ■ Excellent ■

Tracking of outcomes was one of the lowest rated programmatic measures, with more than one in four CSCT team members rating this aspect of the program as fair or poor and only 20 percent rating it as excellent. This is despite the ARM requiring that CSCT contracts "should identify program data and information which will be shared between the school and mental health center to evaluate program effectiveness" and that CSCT ITPs include measurable outcomes.
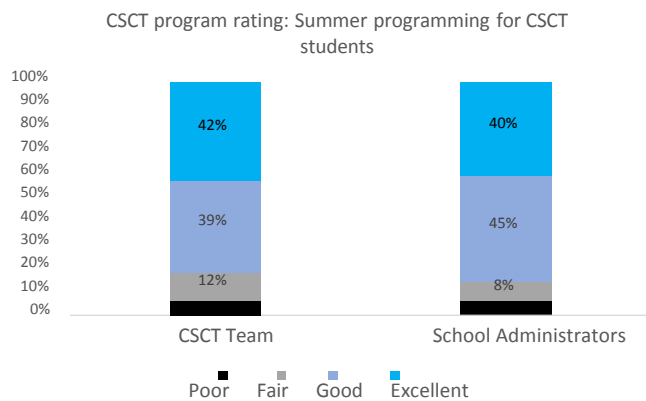
In terms of achieving outcomes, the majority of respondents rated their CSCT program as good, not excellent, at achieving positive behavioral and academic outcomes.

◼ DISCHARGE PLANNING AND WAIT-LIST MANAGEMENT

CSCT program rating: Discharge planning and procedures to move students off the program who no longer need CSCT

	CSCT Team	School Administrators	School Counselors/ Psychologists
Excellent	28%	29%	38%
Good	57%	54%	41%
Fair	12%	14%	14%

Poor   Fair   Good   Excellent

CSCT program rating: Wait-list management

	CSCT Team	School Administrators
Excellent	20%	29%
Good	51%	55%
Fair	23%	13%

Poor   Fair   Good   Excellent

Wait-list management appears to concern some CSCT stakeholders. More than one in four CSCT staff rate their wait-list management as fair or poor. Only 20 percent rate it as excellent.

◼ SUMMER PROGRAMMING

CSCT program rating: Summer programming for CSCT students

	CSCT Team	School Administrators
Excellent	42%	40%
Good	39%	45%
Fair	12%	8%

Poor   Fair   Good   Excellent

CSCT summer programming appears to be one of the most variable parts of the CSCT program as it is implemented locally (see summary comments below) but, in general, survey respondents appear satisfied with their summer programming. More than 80 percent of school administrators and CSCT team members rate their CSCT summer programming good or excellent.
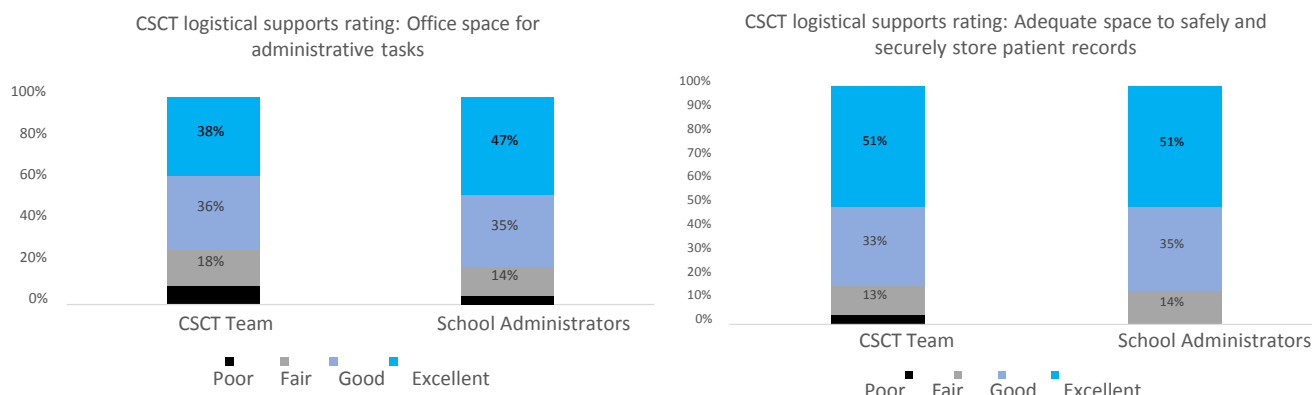
RATING LOGISTICAL ASPECTS OF THE CSCT PROGRAM

ARM 37.87.1802 states that schools must outline the following in their CSCT contracts.

- Program supports, including telephone, computer access, locking file cabinets, and copying that the school will make available for CSCT staff.

- Office space that is adequate and appropriate for confidentiality and privacy.

- Treatment space large enough to host a group during both school and nonschool days.

CSCT team members and administrators were also asked to rate as excellent, good, fair, or poor a number of logistical aspects of their CSCT program that are mentioned in the above ARM. Below is a summary of their responses.
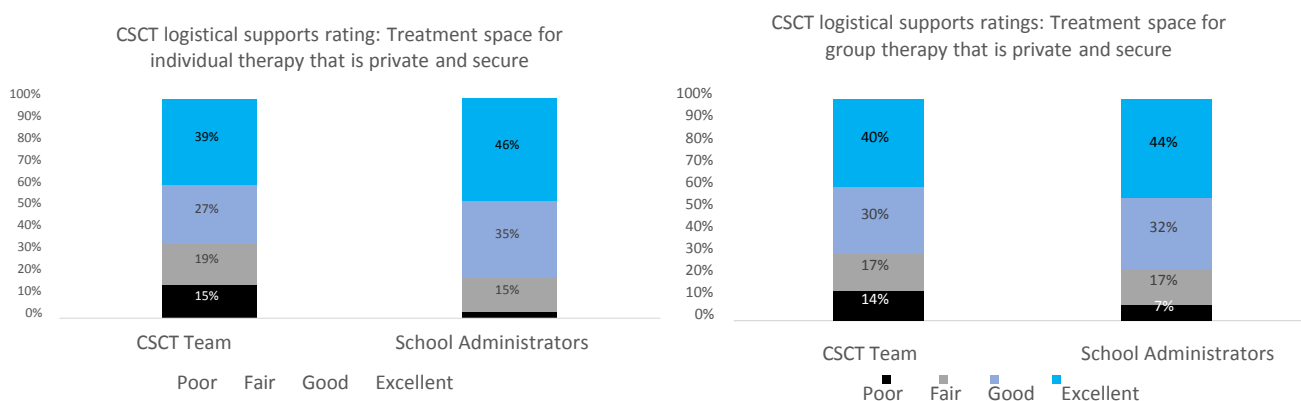
In general, CSCT staff rated the logistical supports for the program less highly than school administrators.

■ ADMINISTRATIVE AND STORAGE SPACE

CSCT logistical supports rating: Office space for administrative tasks

CSCT logistical supports rating: Adequate space to safely and securely store patient records

CSCT staff were less likely to rate their "office space for administrative tasks" as excellent or good compared to school administrators. Both groups generally rated as positive their access to adequate space to safely and securely store patient records.

■ TREATMENT SPACE FOR INDIVIDUAL AND GROUP THERAPY

CSCT logistical supports rating: Treatment space for individual therapy that is private and secure

CSCT logistical supports ratings: Treatment space for group therapy that is private and secure

More than one in three CSCT team members rate their treatment space for individual and group therapy as fair or poor. CSCT team members are more likely than school administrators to perceive their treatment space as inadequate. Based on these ratings, treatment space for both individual and group therapy is one of the largest concerns facing CSCT team members.

■ COMPUTER AND TELEPHONE SUPPORT

CSCT logistical supports rating: Computer and telephone connectivity and other communications support

	CSCT Team	School Administrators
Excellent	46%	65%
Good	31%	31%
Fair	18%	4%
Poor		

Poor Fair Good Excellent
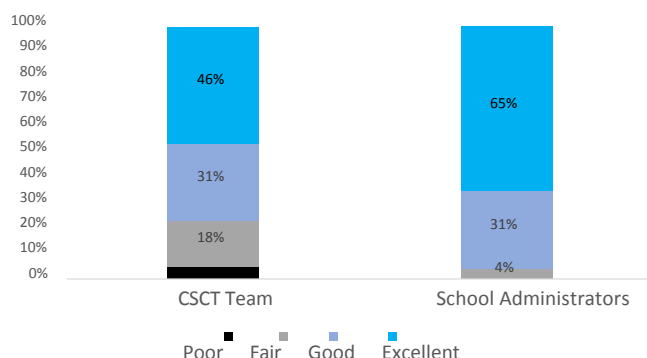
Again, CSCT team members are less likely to rate their "computer and telephone connectivity and other communications support" as good or excellent compared to school administrators, although almost half rated it as excellent.

SUMMARY

In general, the CSCT program is well regarded among CSCT team members, school administrators, and school counselors/ psychologists. However, some CSCT programs do not report operating according to the ARM that govern the program, including only serving students on Medicaid and not implementing CSCT within the MBI/PBIS framework.

Despite positive overall ratings, some aspects of CSCT program were not rated as highly including:

- The size and manageability of CSCT caseloads.
- The creation of effective ITP.
- Coordination with home support services and outpatient therapy, as needed.
- Access to training and support.
- Tracking and achieving positive outcomes.
- Wait-list management.

In terms of logistical supports, most teams in Montana report adequate accommodation, but some teams clearly do not feel that schools provide them the necessary treatment space and technical support required by the program regulations, and these concerns may not be fully understood by all administrators.

Many of these survey themes are described further in the summary of interview and open-ended survey question themes below.

IN GENERAL, THE CSCT PROGRAM IS WELL REGARDED AMONG CSCT TEAM MEMBERS, SCHOOL ADMINISTRATORS, AND SCHOOL COUNSEORS AND PSYCHOLOGISTS.

STRENGTHS AND WEAKNESSES OF CURRENT CSCT PROGRAMS

In October and November 2017, 10 semi-structured interviews were conducted with local CSCT stakeholders. Interviewees included mental health center CSCT supervisors, school administrators, school counselors, CSCT team member mental health professionals, and behavioral health aides. Interviewees, representing both larger AA and A schools as well as in rural and tribal areas, were asked to share their perspective on how CSCT is being implemented in their district, including the strengths and weaknesses of their current programs. In addition, the 319 CSCT electronic survey respondents were given the opportunity to answer open-ended questions about the strengths and weaknesses they perceive in the CSCT programs with which they interact. Below is a summary of common themes described by these stakeholders.

COMPONENTS OF SUCCESSFUL PROGRAMS

From semi-structured interviews and survey responses, a number of key programmatic factors appear to mark CSCT programs that are achieving success. These factors include:

◼ STRONG COMMUNICATION AND TEAMWORK

Schools that report the most success with the CSCT programs indicate that the school staff and CSCT team members have well establish, ongoing communication channels and have fostered a strong sense of teamwork. CSCT team members note, "Our CSCT program has a lot of communication with those involved in the program. We work well together and talk about what needs to be done to support the children in the program in our school.

Our goal is to keep our children in the classroom and work toward helping them emotionally regulate. CSCT is not just the mental health therapist and behavior specialist. In order for the team to see success, the administration, teachers, and school counselors need to work together to support those children."

◼ HIRING EXCELLENT STAFF

Repeatedly, school administrators underscored the vital importance of hiring well-trained, well-matched staff on CSCT teams as a factor that contributes to a successful program. "Our therapists and behavior support specialist are fantastic...the effectiveness of our CSCT program is always reliant on the skill of the adults," noted one administrator.

◼ ADDRESSING TRAUMA AND UTILIZING EVIDENCE BASED PRACTICES

Effective CSCT programs also report utilizing evidence-based practices and incorporating an understanding of trauma and Adverse Childhood Experiences (ACE) into their work. As one CSCT team member put it, "After going to trainings related to trauma-informed care and how to work with communities on reservations, I find that my treatment plans are much better and the work I'm doing with families is more informed and evidence-based." Another CSCT members notes that the strength of her program is "the implementation of research-based tools to accomplish goals and objectives within a treatment plan of a student." The more that programs are research-based and data-driven, the more success is reported by the program.

■ REDUCING THE STIGMA OF MENTAL HEALTH AND TRAUMA

Having CSCT embedded in the school setting reduces the stigma of addressing behavioral health concerns and trauma, which builds understanding and empathy in the school environment for addressing mental health challenges. "The longer we are in a school, the better they understand the impact of trauma, signs of mental illness, and how to work with kids and families," says one CSCT team member. "We see more collaboration and less turf issues."

Having the additional capacity to address behavioral health through the CSCT team can help bring teachers and families along in their understanding of the importance and benefits of mental health services and addressing trauma, through both formal and informal training. "CSCT staff and leadership have been involved in providing training to the school district on trauma and trauma-informed care that has continued to help both CSCT staff and school district staff to grow in their knowledge and abilities to provide care and education for children and families. CSCT is often able to be a bridge between parents who struggle to engage positively with school staff or administrators that strengthens children's engagement in school."

■ FACILITATING IMMEDIATE ACCESS TO SERVICES

One way that CSCT addresses stigma is by providing immediate access to behavioral health services for students with SED in the school setting. One CSCT team member put it this way: "What works well for the CSCT program is the immediate availability of mental health providers for children who need substantial, additional supports." Immediate access to services is critical for many students who receive CSCT. Kristen Bogan, a K-3 special education teacher in Stevensville, Montana, noted that many students receiving services from CSCT, especially in rural communities, might never receive them without the service being embedded in the building. "Kids are getting a wraparound service inside the school so I really appreciate having the mental health team in our building. That wraparound will help them now so that they will not have as many behavioral concerns in middle school and later. And I am not sure that many parents would seek out these services outside the school." Melody Sands, the school counselor at the Harlem Schools, framed it this way: "The huge benefit of CSCT is that they are an 'unofficial member of the school' who are there every day so you can address needs immediately, which is the benefit. These kids don't have coping skills or social skills and you are teaching them *in the moment*, not 'wait until your therapist gets here.' CSCT is there immediately."

■ UTILIZING CSCT AS PART OF THE MBI MTSS AS A TIER III INTERVENTION

CSCT appears to be most successful when it is understood as a Tier III intervention within the MBI framework and is embedded into a robust MTSS system within a school. One school counselor described the success seen in his school this way: "They [the CSCT team members] are an integral part of our universal system. They help implement interventions for our Tier III students who need the most intensive support. They have the specialized skill set, ability, and flexibility to help school person-nel with students who struggle with intense emotional challenges. The success is seen when students who are struggling to self-regulate implement strategies to help themselves from escalating and turning a problem into a crisis." Another school counselor echoed these sentiments. "We love our team here. They are very involved in the MTSS team process and work with all stakeholders. They understand how to use their time wisely and encourage kids to be in the classroom and learning as much as they can. They communicate well with all staff and follow procedures for getting kids support."

OUTCOMES OF SUCCESSFUL PROGRAMS

When the above factors are in place, CSCT stakeholders report that the program is achieving positive outcomes, including reducing behavioral health concerns and increasing academic outcomes. Key outcomes that CSCT stakeholders believe their programs are achieving include:

■ ENHANCING SCHOOL COUNSELING SERVICES WITH MORE INTENSIVE SUPPORT FOR CHILDREN WITH SED

School counselors working with successful CSCT programs extol the benefits of the program for enhancing their capacity to support students by providing intensive, personalized support to students. One school counselor said, "It is so helpful to have the support of the CSCT team, especially for those students who need one-on-one support in the classroom. CSCT has helped take a big load off of my caseload." Another said, "The CSCT program offers students a much more comprehensive, in-depth, one-on-one, personalized therapeutic support system here at the school."

■ IMPROVING BEHAVIORAL OUTCOMES AND REDUCING SUICIDALITY AND THE NEED FOR HIGHER LEVELS OF SERVICE

Many CSCT stakeholders report that the intensive support provided through CSCT to high-risk kids improves behavioral outcomes and reduces the risk of suicide and out-of-home placement. One CSCT team member notes that CSCT "is a very preventative service. I believe it helps many kids that otherwise would fall through the cracks and end up in juvenile justice, chemical dependency, or adult services." Others note that the program can aid in assessing high-needs kids and facilitating access to high levels of service, where appropriate. A CSCT therapist notes, "I'm seeing success in the assessment of suicidal children and informing guardians of the need for higher level of assessment and treatment in cases where the mental health diagnosis is chronic and needs immediate and higher level of attention."

■ INCREASING ATTENDANCE AND ENGAGEMENT IN SCHOOL, INCLUDING A REDUCTION IN DROP-OUT RATES

In terms of academic outcomes, many stakeholders note that they believe CSCT keeps at-risk students engaged in and attending school. One CSCT team member notes, "Children appear to be missing less school and are less disruptive in class. Children are openly processing their feelings and issues." Another argues, "Most [CSCT clients] would either be suspended in or out of school. with CSCT they have the support and learn the tools to help them manage their SED symptoms and behaviors." Another respondent linked CSCT to graduation rates saying, "The kids are graduating! They have a safe space in the school and know that they are welcome anytime. Kids feel that they have a place in the school and are not lost in the system and people that care for them."

WEAKNESSES OF CURRENT CSCT PROGRAMS

Despite the many reported successes of CSCT programs in Montana, program stakeholders also report numerous challenges implementing effective services at the local level. A summary of the weaknesses outlined by interviewees and survey respondents is below.

■ PROVIDER RECRUITMENT AND PAY--ESPECIALLY IN RURAL AREAS

A challenge repeated by many CSCT stakeholders was recruiting and retaining quality staff, particularly in rural districts. Many stakeholders note that CSCT positions pay poorly for work that is emotionally challenging and demanding. As one CSCT team member put it: "Wages for behavioral health aides are very low and expectations for them are very high." A school administrator expressed her frustration this way: "The biggest weakness of CSCT is the lack of qualified candidates applying for the program. We have been without a therapist for several months. This is a demanding job with entry level pay, so people are not sticking with the program for the long term." Because of the taxing nature of the job and the noncompetitive wages, many administrators report high turn-over rates for staff, especially for behavioral health aides and for mental health providers in training who become licensed. "We have two amazing CSCT teams," reports one administrator, "But I worry we lose good people in our CSCT teams due to better wages they can make elsewhere."

The problem of staff recruitment and retention is exacerbated in rural and tribal schools. Several tribal schools interviewed for this evaluation report that they have lost CSCT teams in recent years because the mental health centers they contract with have been unable to recruit providers. These schools indicate that mental health center contractors offer the same pay to CSCT providers working in larger schools and those in remote, rural areas serving high-risk populations. Thus, there is little incentive for providers to move or commute to rural areas and serve in tribal schools. Doreen Warren, the assistant principal at Harlem Elementary on the Fort Belknap Reservation, explained the consequences of losing her CSCT team in recent years because of the inability of the mental health center contractor to fill the CSCT positions. "We had a program at the elementary and high school. When we lost our CSCT therapist, immediately the mental health center started recruiting but no one applied. It's pretty remote up here. The next year, the kids that lost CSCT services, their disciplinary write ups went through the roof. Those kids lost that support. The CSCT therapist saw those kids individually each day, and, since they lost support, it has been really rough." Several tribal CSCT program stakeholders note that it is common practice for tribal and frontier schools to offer higher wages for teachers and paraprofessionals to promote recruitment. They believe that CSCT programs need to do the same if they hope to fill positions and retain staff.

■ EXCESSIVE PAPERWORK

Another challenge expressed by many CSCT team members is the paperwork required to bill for CSCT, which many feel takes away from time spent with CSCT clients. "The workload of paper work is ridiculously large and takes away from the actual work with students and families." "The time we have to spend fulfilling licensing and billing requirements is far out of proportion to the face time we have with kids. When we could be working on what they need, we end up writing about it instead."

■ RESPONDING TO CRISES

CSCT staff also discuss the challenge of serving high needs clients who often have behavioral health crises. One CSCT team member describes the challenge of "Putting out so many 'fires' throughout the day that there is little time to do individual/family work as well as the required notes and other documentation."

◼ REFERRAL PROCESSES AND DEMAND FOR THE PROGRAM, ESPECIALLY IN SCHOOLS THAT LACK A ROBUST MBI STRUCTURE

Many schools indicate that there is a greater demand for CSCT services than capacity to serve students. One counselor lamented that there is "too great of a need. We could use at least one more CSCT team in our district and, preferably, without the barriers of insurance stipulations." Another says, "There seems to be more and more students in need of Tier III interventions. We are limited in how many students can be served." Concerns about demand seem to be exacerbated in schools that are implementing CSCT without a robust MBI/MTSS process in place. Districts without fully developed Tier II services

report that students are often referred directly to CSCT when behavioral issues arise, resulting in many students referred to CSCT that might be able to be served at lower levels of support if robust Tier I and II services were present. One CSCT team member notes, "The referral process still remains challenging as many Tier II MBI interventions have not been implemented before being referred to our program." Another echoes this sentiment: "One of the major barriers is no tier system in place. The CSCT program receives referrals that could otherwise be served by Tier II interventions."

◼ COORDINATING VARIOUS SERVICES AND SUPPORTS AND BRINGING IN CULTURALLY APPROPRIATE SERVICES IN RESERVATION AREAS

Another challenge facing CSCT programs is coordinating services, including school counseling, special education, and outpatient services for students with complex needs. One administrator wrote, "The only challenge I experience is having one school counselor that does not work openly with our CSCT people and will not work with the student if CSCT is involved. That is not how I envision the process or assistance." Coordinating services requires ongoing systems of communication, which are not

always in place at all schools. As one school counselor notes, "The only barrier I see at times is communication. Sometimes, we are not notified if a student is being discharged or what therapeutic approach they are using. Communication falls short especially when it comes to a child's treatment plan. it is not explained or gone through with support staff."

◼ ENGAGING FAMILIES

Another coordination and communication barrier for many programs is engaging families in the CSCT process. Melody Sands, principal at Harlem Elementary notes, "One of the things that was the most frustrating with CSCT is that the kids with the highest need couldn't get services Because we couldn't engage families in services that weren't mandated." Even when families do agree to services, CSCT programs note that they are often overwhelmed by the many meetings required by the programs serving their children: from CSCT to special education,

outpatient therapy, and beyond. Kristen Bogan of Stevensville Primary notes, "Sometimes it's a lot of meetings for the parents, although we do try to streamline it for them. CSCT does come to parent/teacher conferences and other special education meetings with the parents so that we can show them how we are collaborating for their kids. If they are working parents, attending all of these meetings is hard for them."

◼ PROTECTING STUDENT/PATIENT CONFIDENTIALITY WHILE SHARING NEEDED INFORMATION TO COORDINATE SERVICES

Communication challenges with CSCT are further exacerbated by disparate policies in local school districts about sharing student information. Some school districts bar CSCT team members from participating on student support teams or sharing information about student's treatment plans in order to protect confidentiality. These policies arise from varying interpretations of federal HIPPA and FERPA regulations related to student confidentiality. Chad Berg, the CSCT coordinator in the Bozeman Public Schools notes that information sharing policies "can lead to siloing and not sharing information. But, we need to understand what we can share and how we can coordinate services. CSCT is a contract provider and an agent of the district and we need to help teams understand that we are all working under the auspices of the district. Our special education team doesn't need to know everything about the family, but they sure need to know the treatment plan. There should be some dovetailing. We have complementary goals and this is allowed under federal law." More understanding is needed in many local districts of what can be shared between CSCT teams and school staff and how this can be done without violating federal law or client confidentiality.

◼ SCHEDULING AND RESISTANCE TO TREATMENT

Logistically, many schools note that a major concern with CSCT is scheduling time for individual and group therapy sessions outside of the classroom during the school day in a way that doesn't disrupt the academic processes. The need to remove children from classes can cause resentment from teachers who may not see the value of behavioral interventions. In some schools, teachers perceive CSCT as a break from class or a reward that enables problem behaviors, so they are resistant to students participating in the program. One administrator succinctly summarized the problem as "balancing therapy time with academic time."

◼ ACCESS TO TRAINING

Some CSCT teams note that they aren't provided with relevant or adequate training by either the school or the mental health center who own the CSCT contract. Training concerns include a lack of orientation for new staff about CSCT and its role in the school, lack of training for behavioral health aides who do not have experience with mental health or school-based services, and inadequate continuing education training for CSCT teams that is robust, evidence-based, and applicable to their complex and changing roles.

◼ PROVIDING SERVICES TO STUDENTS WHO DO NOT QUALIFY FOR MEDICAID

As discussed above, providing CSCT services to students without Medicaid is a challenge in many districts. Lisa Lowney, the principal of Kessler Elementary School in Helena notes, "My understanding has been that if students did not qualify for Medicaid, they got partial CSCT services, not full CSCT. So, for over 12 years working in this program, I felt like there were times when kids should have been getting support, but they didn't because they were not on Medicaid." Chad Berg of the Bozeman Public Schools insurance states that billing considerations are often foreign to the public school system. "Public schools operate in the paradigm that all kids should have access to the services they need and that children and families should not have to pay for services. CSCT has to work with non-Medicaid families to come to the table and determine how are they going to pay for the service, and it is a challenge. It's difficult for a school team to come to grips that a family can decide if they want the service and if they will pay for it. We often have kids in the CSCT program with a high level of need and a frequent level of service, so, even with a sliding fee schedule, the services are still expensive and families refuse them."

■ SPACE FOR CSCT

A final and persistent problem with CSCT is securing adequate treatment space for CSCT. Lisa Lowney, an elementary school administrator, reports that her school currently does not have CSCT because the building lacks a treatment space. She explains: "Space is always a problem in any building. There aren't many buildings that have a great CSCT room. Here we have two possibilities: forcing the team to share an office with other staff or taking over the faculty lounge. Neither is feasible." CSCT team members discussed how the constant shuffling of their program due to lack of space causes stress and programmatic disruptions. "We struggle with space, constantly moving offices, and what we are allowed to do and not do because we are not school employees."

CONCLUSION

Despite the many challenges of CSCT, the program does provide personalized, behavioral health interventions to thousands of students with SED in the state ever year. When CSCT is being implemented according to best practices and students are achieving positive outcomes, CSCT services are highly valued by administrators, teachers and other staff. One administrator expressed his support for the program this way: "Many kids on the CSCT caseload would not be able to function in a typical school environment without the CSCT support. Onsite CSCT support helps students with mental health challenges manage their emotional state to enable them to learn while at school. The CSCT team also helps teachers to understand the unique challenges some of our students face that builds understanding and empathy and helps to build solid relationships between the teacher and the student's family unit." CSCT has become so integral in some local districts that even school buildings are being designed to accommodate the program. Kim Chouinard, the executive director of the Yellowstone Girls and Boys Ranch, reports that "Billings just opened a new middle school in fall 2016, and they built CSCT offices into the design of the school."

School staff operating CSCT programs report a variety of challenges to implementing the program effectively. However, when the program is operating according to best practices, stakeholders report that a wide range of positive health, behavioral, and academic outcomes are being achieved. Though these insights merit more rigorous and quantitative evaluation, they are a helpful starting point in understanding the value of this service in Montana schools.

DESPITE THE MANY CHALLENGES OF CSCT, THE PROGRAM PROVIDES PERSONALIZED, BEHAVIORAL HEALTH INTERVENTIONS TO THOUSANDS OF STUDENTS WITH SED IN MONTANA EVERY YEAR.

PART TWO

Recommendations for model CSCT programs in Montana

Based on the strengths and weaknesses detailed in Part One of this report, this section outlines a number of key recommendations for developing model CSCT programs in Montana. These recommendations include suggestions for creating model CSCT programs within the existing CSCT billing and regulatory framework. Ultimately, CSCT programs in Montana should incorporate the best evidence for linking school mental health programs with MBI/PBIS/MTSS, address behavioral concerns among students with SED using evidence-based practices, align with the ARM that governs the program, and be designed to incorporate the lessons learned from programs operating on the ground. These best practices should be reflected in the CSCT contracts initiated by the school districts with mental health center CSCT providers. The following recommendations arise from feedback from Montana CSCT stakeholders and national experts as well as the published literature in the field.

EMBED CSCT WITHIN MBI/PBIS/MTSS

CSCT is, at its core, a system for providing school mental health services to children with SED. According to published research, school mental health services are more effective when embedded in a robust MBI/PBIS/MTSS system that addresses mental health promotion for all students.[2]   The state of Montana works to assist schools in their efforts to link MBI and CSCT. A 2013 update to the ARM governing CSCT programs added language requiring CSCT contracts to include language about PBIS implementation, referred to as MBI in Montana. The new rule language (see ARM 37.87.182) adopted in July 2013 requires that CSCT contracts describe the following aspects of the PBIS system used at the school site.

- How the school identifies youth who exhibit inappropriate behaviors and need a PBIS plan and youth at risk of, or suspected to have need of, mental health services.

- How the school Implements and monitors the progress of a PBIS plan for effectiveness.

- How the school will refer youth to the CSCT program when PBIS has not resulted in behavior change and/or when the youth may have a clinical condition that needs to be addressed.

In addition to these rule changes, in the past 10 years, Montana has developed a statewide school mental health Community of Practice and incorporated information on school mental health into its statewide MBI conference, developing an entire track at the conference about incorporating school mental health into MBI using the Interconnected Systems Framework (ISF).

Despite these efforts, the evaluation data presented in Part One of this document indicates that many schools with CSCT teams either are not implementing MBI/PBIS/MTSS or, more commonly, are not fully embedding CSCT as a Tier III intervention within their MBI model. Robert Horner, codirector of the Office of Special Education Programs (OSEP) Technical Assistance Center on PBIS argues that school mental health services will be inefficient without robust MTSS undergirding them. "Schools are not using Tier III mental health services effectively unless they also have Tier I and II supports in place. Tier III interventions are overly intensive and expensive for many students who can be effectively supported at the lower tiers."

To avoid misappropriating resources and to ensure that CSCT services are correctly designed and targeted, schools with existing CSCT programs, or those considering developing CSCT programs, should evaluate the relationship between their MBI framework and CSCT. Schools should ensure that MBI is fully operational at all Tiers and that students being referred to CSCT have first been fully supported at the Tier I and II levels. In addition, even when students are referred to CSCT, Tier I and Tier II supports should continue to be implemented with fidelity to fully support the student's academic and behavioral success.

UTILIZE MBI STUDENT SUPPORT TEAMS

A key component that schools must have in place to link CSCT and MBI schools are student support teams; often referred to as assistance teams, MTSS teams, Tier II teams, or problem-solving teams. Schools should utilize multi-disciplinary student support teams to conduct behavioral assessments, analyze individual student data, and design Tier II and III behavioral interventions and supports, including referrals to CSCT. This approach helps ensure that referrals to CSCT are appropriate and reduces the large caseloads and wait-lists that plague some programs.

If CSCT providers are receiving inappropriate referrals, they should work with the school's student support team to better optimize the referral process. Schools should ensure that students with behavioral issues are first referred to the student support team where they are assessed and provided appropriate, lower levels of support before referral to CSCT. If a CSCT provider assesses a student referred to their program and finds that he or she could be effectively supported at a lower tier, the provider should refer the student back to the MBI student support team for appropriate Tier I and II supports.

CONSIDER USE OF THE INTERCONNECTED SYSTEMS FRAMEWORK

One research model that can assist Montana schools in embedding CSCT services into MBI is ISF. ISF is designed to ensure that school mental health initiatives are integrated, not just "co-located," with Tier I and Tier II supports and that school staff are knowledgeable, not suspicious, of services like school mental health services. ISF addresses limitations of both PBIS and school mental health by systematically linking these systems and adding depth and quality to the multitiered system of prevention, intervention, and support.[3] The core features of ISF include: (1) effective teams that include community mental health providers, (2) data-based decision making, (3) formal processes for the selection and implementation of evidence based practices, (4) early access through use of comprehensive screening, (5) rigorous progress-monitoring for both fidelity and effectiveness, and (6) ongoing coaching at both the systems and prac-tices level.[4]

Work has already been done in Montana to promote the use of the ISF. The OPI has offered ISF trainings at the MBI Summer Institute as well as at the School Counselors Association Conference in the spring of 2017. At the local level, several school districts have worked to implement ISF in their districts in recent years, including the use of CSCT as a Tier III MBI/MTSS service. They have done this work with the help of trainer Rebecca Harris. Use of the ISF framework has improved the effectiveness of CSCT referrals and MBI/CSCT integration places like the Butte School District. Other districts across Montana can learn from these success stories and should consider ways to better understand and develop an ISF in their local systems.

EVIDENCE-BASED PRACTICES TO CONSIDER FOR CSCT
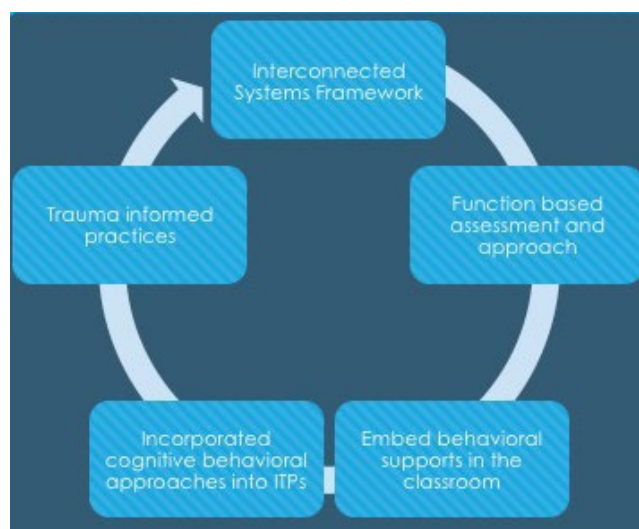
UTILIZE EVIDENCE-BASED BEHAVIORAL SUPPORTS AND THERAPIES

After a school has provided robust Tier I and II supports to students, some students will still require additional interventions to adequately address their behavioral health concerns and be referred to CSCT. Students who are referred to the program should receive an evidence-based assessment that informs the development of an ITP. As the ISF framework underscores, schools must develop a formal process utilizing a treatment planning team to effectively assess student's behavioral health needs and select evidence-based therapeutic and behavioral interventions to incorporate into their ITP.

The ISF framework lays out the following steps for student assistance teams developing ITPs for Tier III students.

- Specify the individual student need and intended outcomes.

- Select the most appropriate evidence-based practice.

- Ensure that the selected practice is adaptable to the local context and culture.

- Provide support for implementation.

- Have a process in place for system level continuous progress monitoring planning.[5]

Ultimately, according to the ISF, ITPs at the Tier III level should include the following components.

- Intensive, individualized, function-based behavioral interventions that include antecedent, instructional, and consequence strategies.

- School mental health professionals providing evidence-based treatment services to indicated students (e.g., cognitive behavioral therapy).

- Additional student and family supports developed through a collaborative process.[6]

The following recommendations for Montana schools arising from the ISF model for designing Tier III interventions.

UTILIZE FUNCTIONAL BEHAVIOR ASSESSMENTS AND INTERVENTIONS

One of the most effective approaches for students with behavioral health concerns is a functional behavioral approach. Under this model, Functional Behavioral Assessments (FBAs) are used to identify antecedent conditions that set the stage for undesirable (target) behaviors to occur and the maintaining consequences. Once these factors are understood, a Behavioral Intervention Plan (BIP) is designed based on the function of the target behavior.[7] The functional behavioral approach allows schools to adopt a preventative lens, including better designing the learning environment and school staff interactions in ways that remove or mitigate the antecedent conditions that trigger problem behaviors while supporting teachers to implement effective instructional strategies and appropriate consequences when behaviors do occur.

The national OSEP PBIS Technical Assistance Center describes the functional behavioral approach at Tier III this way, "The Functional Behavior Assessment (FBA) is the process that drives a function-based BIP and provides the foundation for a systematic, coordinated, data-driven problem-solving process, which, in turn, ensures that interventions lead to improved student outcomes."[8] The FBA process is crucial to (1) understand the variables associated with or maintaining a student's behavior, (2) develop strategies to prevent challenging behavior, and (3) determine interventions that can teach and reinforce appropriate or prosocial behaviors.[9]

Research indicates that the use of a function-based approach is effective in support students with SED in the classroom. In a recent study, Pinkelman and Horner (2017) conclude that "effective implementation of function-based interventions to teach socially appropriate behavior and decrease problem behavior is of utmost importance in schools."[10] The focus on antecedent-based strategies is particularly important for designing effective interventions. In a study of students in a general education classroom who exhibit excessive rates of disruptive behavior and poor academic engagement, Restori et al. (2007), found that "antecedent-based treatment strategies such as self-monitoring and task-modification were more effective than consequent-based treatment strategies (i.e., self-monitoring and reinforcement) for increasing academic engagement and reducing disruptive behavior.[11]

Unfortunately, Restori and others report that antecedent-based approaches are often not well utilized in schools.

Because of the evidence supporting the use of a functional behavioral approach for students with behavioral health concerns in schools, MBI and CSCT teams in Montana should consider how to conduct FBAs and develop CSCT ITPs that incorporate functional behavioral interventions. The implementation of a functional behavioral lens in Montana may look different than the approach used elsewhere in the country, especially in rural and frontier schools, but MBI and CSCT teams should at least consider ways to incorporate this evidence-based approach into their assessment of and intervention design for students.

Schools should delineate the CSCT team's role in conducting FBAs and developing and implementing ITP/BIPs in conjunction with the school counselor/psychologist, student, their family, their teachers, and the MBI team at the school. Ultimately, a strong partnership between the school psychologist, who may be best equipped to conduct an FBA, and the CSCT and student support team may be needed. The school should adopt policies that allow appropriate sharing of student FBA results between these parties while appropriately protecting student confidentiality vis a vis HIPAA or FERPA (see section below).

Some CSCT programs in Montana are already effectively utilizing a functional behavioral approach, with clear roles for CSCT teams in the process. Schools in Hamilton and Stevensville interviewed for this project shared how FBAs are the basis for their MBI interventions and CSCT services. Jacqueline Brazil, a

behavioral health aid in Hamilton Middle School, describes their process this way: "We work with the school psychologist or the counselor to do a FBA, which is very practical. It assesses what behaviors the student has and setting events like background trauma or chaos, unstable living conditions, or diagnoses. The FBA is very structured and allows us to develop a behavioral plan so everyone knows what to do. After the FBA, we develop an individualized behavior plan and a behavioral intervention tracking tool. Any time a teacher attempts an intervention with a student (e.g., having them work with another student, moving them to another seat) the intervention and result are recorded. These data are utilized by our grade level teams to determine how best to support the student and if he or she needs a referral to CSCT. If there is nothing in the tracker and a teacher thinks the student needs a referral to CSCT, our principal will say, 'we haven't tried A and B, we're not going on to C.' Once a student is in CSCT, my job as the behavioral health aide is to look at the intervention tracker and look at what is working. I go into the classroom and see what interventions are working and work with the teachers to best support the student." Utilizing a problem-solving team, collecting systematic data, and utilizing the functional behavioral lens is helping Jacqueline's school implement a model that is evidence-based and appropriately targets CSCT as a Tier III MBI intervention.

Examples of functional behavioral assessments and behavioral plans, including the tools used in Hamilton Middle School, are located in Appendix I.

EMBED BEHAVIORAL SUPPORTS IN THE CLASSROOM

As stated above, a comprehensive BIP will include roles for CSCT team members and require teachers to be trained to implement functional behavioral interventions on an ongoing basis with the student. Research findings support the use of classroom-based approach that reduces the amount of time students are removed from their academic environment. In a review of PBIS interventions and culture, Fallon et al. (2012) found that "students who spend more time outside the classroom because of disciplinary consequences are at increased risk for negative outcomes such as diminished academic indemnity, deficient academic skills, and higher attrition."[12]

Thus, one role that CSCT teams should play is to support students and teachers in the classroom to implement functional behavioral interventions outlined in the student's ITP. As noted above in the example from Hamilton Middle School, CSCT behavioral health aides can play a supportive role for teachers in the classroom as they design and implement interventions. This "coaching" role that CSCT staff might adopt with teachers is supported by the research. A 2017 study by Pinkelman et al. found that training for teachers on implementing behavioral supports by itself did not result in positive implementation or intervention outcomes. Instead, to implement these interventions to fidelity, teachers needed to receive feedback from an expert or coach.[13] A recent literature review of studies looking at interventions where teachers were coached on the use of social behavior interventions to improve children's social behavior outcomes found that 86 percent of studies documented positive findings. In the study, Stormont et al. (2015) conclude that "coaching is an important method for providing needed supports to teachers".[14]

The coaching role for CSCT teams was supported by national experts interviewed for this project. Robert Horner, codirector of the OSEP PBIS Technical Assistance Center recommends that school mental health staff be utilized, not only to provide therapy to students, but to actively build the capacity of teachers and all school staff to address behavior in the classroom. This approach avoids the problem of "schools viewing mental health services as a process for excluding students with problem behavior until they are 'fixed.'" Instead he argues, "Schools need to use mental health services to address behavioral health concerns comprehensively."

Embedding CSCT behavioral supports in the classroom also addresses a concern expressed by many CSCT stakeholders in interviews and survey responses. These school staff indicated that a weakness of the CSCT program is the time away from the classroom that is required for therapy or other interventions. Many school staff viewed the program as taking time away from academics. One counselor framed her concern this way, "CSCT programs cannot be a place for a student to escape and then avoid classwork, which is why a school-based behavior plan is a key to an effective program." More deeply incorporating CSCT team members into the classroom to observe and support behavioral interventions and build the capacity of classroom teachers to implement these interventions on an ongoing basis addresses these expressed concerns.

INCORPORATE EVIDENCE-BASED THERAPEUTIC INTERVENTIONS INTO ITPs

Alhough CSCT should play a role in implementing classroom-based behavioral interventions, many students with SED in the CSCT program will still require intensive, individualized therapeutic support from the CSCT mental health professional. CSCT provides a unique opportunity for schools to provide these therapeutic supports to students in the school building, without the need of bringing in outside mental health professionals. As with classroom-based behavioral interventions, when CSCT group or individual therapy is provided, it should be evidence-based, preferably taking a cognitive behavioral approach and incorporating a trauma-informed lens.

One evidence-based cognitive behavioral and trauma-informed intervention highlighted by several experts interviewed for this project was Cognitive Behavioral Intervention for Trauma in Schools (C-BITS), also known as Bounce Back. C-BITS is a school-based, group and individual intervention designed to reduce symptoms of post-traumatic stress disorder, depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills. CBITS has been used with students from fifth through twelfth grade who have witnessed or experienced traumatic life events. The intervention includes 10 group sessions followed by one to three individuals utilizing a set curriculum. C-BITS has been shown to positively affect trauma and stress related disorders and symptoms, anxiety disorders and symptoms, and social competence. It has also shown promise in a number of studies for improving self-regulation and educational achievement.[15] CSCT mental health center providers should consider ways to facilitate training on C-BITS and other evidence-based therapeutic models for CSCT teams statewide.

The scope of this paper does not allow for a review of all of the potential evidence-based therapeutic approaches for students on CSCT. However, there are many options for CSCT providers to consider outlined on SAMHSA's National Registry of Evidence Based Practices. When developing contracts with CSCT mental health center providers, schools should discuss with the CSCT provider the range of evidence-based therapeutic approaches the team will be trained in and able to provide to students. When appropriate, schools should consider including language requiring the use of evidence-based cognitive behavioral and trauma informed approaches by the CSCT provider in their contracts.

DEVELOP AN EFFECTIVE REFERRAL PROCESS

ARM 37.87.1802 requires that CSCT contracts outline a referral process for CSCT. Priority groups for referral are specified in ARM 37.87.1801. To meet these regulatory requirements and limit the size of the CSCT wait-list, a clear, well-defined CSCT referral process is essential. Just like the CSCT individual treatment plan for each student, every school's referral process will be unique to their CSCT program and building culture. However, a few general principles characterize effective CSCT referrals systems:

- Referrals are processed through a CSCT problem-solving team that meets regularly.

- Before a student is referred to CSCT, the problem-solving team ensures that appropriate Tier I and Tier II interventions have been implemented and proved insufficient.

- At the Tier II and III levels, data on the function of student behavior and the use of behavioral interventions is systematically collected and analyzed to monitor student progress.

- Teams systematically document how they are screening referrals and prioritizing them according to criteria listed in ARM 37.87.1801, regardless of payer.

A number of CSCT program personnel interviewed for this project described utilizing referral systems that meet some or all of the above criteria. Kim Chouinard of the Yellowstone Girls and Boys Ranch described the referral process for their CSCT programs this way: "We have a defined referral process, but it works a little bit differently for different schools. Our teams are strongly encouraged to develop a referral meeting at least monthly to talk about all of the referrals, then they prioritize the highest needs kids starting with the criteria from the administrative rules."

Kristen Bogan, a special education teacher in Stevensville, notes that the CSCT referral process in her building is "a very clear-cut process, not just filling out a bunch of paperwork. Instead, we ensure that Tier I and Tier II behavioral interventions have been tried before a student is referred to Tier III. It is a really clear process of decision rules on how the referral has to happen."

In short, an effective referral process is part and parcel of CSCT being well integrated into the MBI/MTSS process in a school, as describe in the previous section of this paper. The more systematized this process is and the more robust the use of Tier I and Tier II supports for students, the more appropriate CSCT referrals will become with fewer overall referrals for only the highest need students for whom an individualized treatment plan is appropriate. With 15 percent or more of CSCT teams and school counselors or psychologists rating their CSCT referral process as fair or poor in the survey conducted for this evaluation and 23 percent of CSCT teams rating the size and manageability of their CSCT caseloads as fair or poor, there is room for improvement in this area of the program in some schools.

Examples of referral process schematics for existing CSCT programs are included in Appendix II.

CHARACTERISTICS OF EFFECTIVE CSCT REFERRAL SYSTEMS

- **Referrals processed through a CSCT problem-solving team that meets regularly.**

- **Before a student is referred to CSCT, the problem-solving team ensures that appropriate Tier I and Tier II interventions have been implemented and proved insufficient.**

- **At the Tier II and III levels, data on the function of student behavior and the use of behavioral interventions is systematically collected and analyzed to monitor student progress.**

- **Teams systematically document how they are screening referrals and prioritizing them according to criteria listed in ARM 37.87.1801, regardless of payer.**

INCORPORATE TRAUMA-INFORMED PRACTICES INTO CSCT

In recent years, schools and mental health providers have learned more about the impact of ACE and trauma on student health, behavior, and academic performance. Unfortunately, children in Montana suffer from high rates of exposure to adverse experiences known to impact health. Montana has among the highest reported ACE scores in the U.S. Fifty-two percent of Montana children aged 0 to 17 report at least one ACE and 17 percent have three or more ACE. Compared to other states, Montana has the highest percentage of children living in a home with a parent or guardian who has alcohol or drug problems (19 percent) or with a mental illness (14 percent). Montana is also in the top quartile among all states for the percentage of children who have experienced divorce/separation (26 percent) and domestic violence (10 percent).[16]

There are a number of interventions that address the impact of trauma and ACE on health that are relevant for consideration and use by CSCT programs in our state. These include:

■ TRAUMA-INFORMED APPROACHES

As schools begin to understand the wide-ranging effects of trauma, some have begun to develop broad-based, systems-level approaches to address trauma through training, policy change, disciplinary practices, and academic systems design. National models, like the Wisconsin School Transformation Project and the Collaborative Learning for Educational Achievement and Resilience Project out of Washington State University, provide examples of how some schools are transforming their entire school culture into one that is trauma-informed. School-level initiatives involve a multi-pronged approached to change building culture including training for staff on ACE and trauma, building a supportive school climate that honors cultural differences and incorporates an understanding of how trauma impacts behavior, and adopting disciplinary policies that are less punitive and keep students engaged in the academic environment instead of shifting them to the justice system.[17]

■ TRAUMA SPECIFIC INTERVENTIONS

In addition to systems and policy change, a range of evidence-based clinical interventions have been developed that specifically address trauma and its impact on mental and behavioral health. SAMHSA defines these trauma-specific interventions as "prescribed, well-researched models shown to be effective in treating trauma for specific individuals or groups in a defined setting."[18]

School mental health initiatives like CSCT should consider the use of these interventions for students with high ACE scores and extensive trauma histories. The clinical intervention C-BITS that is described in the previous section of this report is one such trauma-specific intervention.

INCORPORATING TRAUMA-INFORMED PRACTICES CONTINUED

Some schools across Montana report that they are already implementing trauma-informed approaches and interventions and are systematically incorporating these approaches into their CSCT and MBI frameworks. Kim Chouinard of the Yellowstone Girls and Boys Ranch, a CSCT provider in the Billings area, describes how her program utilized grant funding to improve their staff knowledge and use of trauma-informed practices. She says, "We just completed the requirements for a grant related to trauma-informed care. All of our staff have been trained in Trauma-Informed Care 101 and all of our therapists have been trained in Trauma-Informed Care 201 to implemented trauma informed approaches. This training has been really eye opening for our staff. It has helped provide them with the language to better explain what is going on with our CSCT clients in schools and with skills to better support them."

The Bozeman Public Schools, through the federal National Institute of Justice School and Family Engagement Trauma-Informed grant, have also incorporated trauma-informed approaches into their CSCT and MBI frameworks. Through the grant, Bozeman trained all of their school staff on trauma-informed Tier I approaches and funded masters level counselors and social workers to deliver Tier II and Tier III groups to implement manualized intervention programs that are trauma informed. Throughout the grant, the school district specifically partnered with CSCT to co-facilitate treatment groups and train CSCT staff to implement their services using a trauma-informed lens. In discussing lessons learned from this initiative, Chad Berg, the director of special education services in the Bozeman Public School District, underscored the benefits of coaching for school and CSCT staff to truly embed trauma-informed practices into every aspect of their work. "The most important aspect of trauma-informed services is that it has to become deeply ingrained how your school works with kids and families. It's easy to sit through a training and then fall back into old patterns."

To improve adoption of trauma-informed approaches and interventions in Montana schools, CSCT teams should work to bring training on ACE and trauma-informed approaches to school staff and families by either providing the training themselves or partnering with organizations like Elevate Montana and their statewide network of master ACE trainers.[19] The OPI has recently developed a training entitled, "Overcoming ACE's In MT Schools: Childhood Trauma and Its Impact on Learning" that will be available on the OPI Teachers Learning Hub (Hub) for all school staff and CSCT providers in January or February 2018. School staff and CSCT teams should also partner to evaluate how to better incorporate trauma-informed approaches and interventions into their MBI/MTSS model and CSCT services, including screening students at Tiers II and III for ACE and resiliency scores.

SET CLEAR EXPECTATIONS FOR CSCT PROVIDERS, CLIENTS, AND STAFF

As indicated by the survey results for this project, developing clear expectations and open channels of communication between schools and CSCT programs are areas of concern for some programs. Less than a third of CSCT team members and school administrators rated "clarity of expectations between mental health providers and the school" as excellent in the survey conducted for this report. Less than half of all respondents rated the "clarity of expectations for students about the role and purpose of CSCT" as excellent. Developing clear expectations and educating school and family stakeholders about the purpose and importance of CSCT is critical because the program is such an intensive service that can effectively support high-risk students in a way that the traditional school mental health model cannot. For this to happen, however, families and school staff must be engaged and supportive.

Though the list of expectations for CSCT programs in local school districts will vary, a number of general principles should guide schools in the development and sharing of expectations between CSCT providers, schools, and clients.

- Expectations should be as explicit and clear as possible. Signed, written agreements are preferable.

- CSCT contracts, which outline many program expectations, should be developed by school district and mental health center administrators. The program expectations outlined in the contract should be vetted and shared widely with the individuals implementing the program.

- Expectations should be regularly reviewed with relevant parties, including with clients and families at 90-day treatment plan reviews, with teachers in ongoing CSCT trainings, and in problem solving and administrative team meetings with CSCT supervisors, providers, and schools throughout the school year.

To improve the clarity of expectations between CSCT stakeholders, some programs have developed written expectation handouts that outline what each party can expect from the program. These handouts or signed agreements become a starting point for an ongoing conversation between CSCT stakeholders, schools, students, and families to ensure that expectations are being met and that all parties are on the same page. Examples of the expectations handouts, adapted from handouts utilized by CSCT programs operated by the Yellowstone Girls and Boys Ranch, are located in Appendix III.

GENERAL PRINCIPLES FOR SETTING CSCT EXPECTATIONS

■Expectations should be as explicit and clear as possible. Signed, written agreements are preferable.

■CSCT contracts, which outline many program expectations, should be developed by school district and mental health center administrators. The program expectations outlined in the contract should be vetted and shared widely with the individuals implementing the program.

■Expectations should be regularly reviewed with relevant parties, including with clients and families at 90-day treatment plan reviews, with teachers in ongoing CSCT train-ings and in problem solving and administrative team meetings with CSCT supervisors, providers and schools throughout the school year.

DEVELOP COMPREHENSIVE CONTRACTS THAT FOLLOW MONTANA ARMS

ARM 37.87.1802 requires that "the licensed mental health center providing CSCT services must have a written contract with the school district." Fundamentally, a CSCT contract is a legal document initiated by the school district that allows a mental health center CSCT provider to bill under the school district's Medicaid provider number of CSCT services. Under this framework, school districts are primarily responsible for creating a CSCT contract that meets their district's needs, follows the regulatory framework for CSCT set out in the ARM, and aligns with best practices.

As mentioned above, these contracts are foundational documents that guide the implementation of programs and set a baseline for stakeholder expectations. Unfortunately, as has already been mentioned, these contracts do not always include the input of the individuals who will be implementing the program. As Kim Chouinard of Yellowstone Girls and Boys Ranch notes, "Contracts are done with the school board and superintendent, so the process doesn't always filter down to the school level. There is a disconnect there." In addition, there are aspects of the CSCT

contracts that vary widely between schools and that are not as clear in the state ARM. Chad Berg of the Bozeman Public Schools notes, "There is a lot of mystery around what the CSCT program is required to provide and what is in the contract, especially in terms of summer services. School districts have to be savvy to know the administrative rules. We must follow the ARM requirements, but different providers handle the requirements differently."

For the purposes of this report, the evaluator reviewed a number of existing CSCT contracts. The table below outlines key program elements that might be addressed in the CSCT contract, with any corresponding ARM requirements listed. Example provisions for each program element that schools have included in existing contracts are also listed. These provisions are summarized, not taken verbatim, from contract language. The table includes commentary on instances where the reviewed contracts lacked adequate provisions to meet the ARM requirements.

■ EXISTING CSCT CONTRACT PROGRAM ELEMENTS, ARM REQUIREMENTS, AND EXAMPLE PROVISIONS

ELEMENT	COORESPONDING ARM REQUIREMENTS	EXAMPLE PROVISIONS IN EXISTING CONTRACTS
HIRING	Not covered	The CSCT provider will allow at least one school district employee to be involved in hiring process for CSCT staff.
STAFFING	ARM 37.106.1956--CSCT must employ sufficiently qualified staff to deliver all CSCT services to youth as outlined in the ITP for the youth and in accordance with the contract between the school and mental health center. ARM 37.87.1802--The contract must identify each school in which CSCT services will be provided including staffing by position and minimum qualifications. CSCT staffing specifications are in ARM 37.106.1956. These specifications are not required to be written into the contract.	• The CSCT provider will employ and maintain adequate staffing. Staffing gaps greater than five consecutive school days will be arranged for with the clinical supervisor. • The school reserves the right to terminate services after a five consecutive day staffing gap. • The CSCT provider will ensure that all staff ratios and caseload requirements meet current state and federal standards. In the case of unforeseen circumstances, the CSCT provider may temporarily stop providing services in the absence of qualified staff but will provide unbundled services, when possible, until qualified staff is retained. • The provider will incorporate feedback from the school into personnel evaluations.

ELEMENT	COORESPONDING ARM REQUIREMENTS	EXAMPLE PROVISIONS IN EXISTING CONTRACTS
REFERRAL PROCESS	ARM 37.87.1802--The school and mental health center must identify in the contract a referral process for CSCT and an enrollment process that includes the CSCT licensed or in-training mental health professional and a school administrator or designee to ensure youth have access to services prioritized to acuity and need. Considers the current CSCT wait-list. Referrals must be made in the order specified in ARM 37.87.1801, but this is not required to be written in the contract.	• All referrals shall be in writing following "CSCT Referral Process" as outlined a flow chart document attached to the contract. • School and provider will follow the sequential order of referral as laid out in the ARM. • Referrals will be in writing and will be made to the school problem-solving team, who will review and prioritize referrals according to the ARM requirements. • CSCT services are provided to students via eligibility criteria and referral process that is separate and distinct from eligibility criteria and referral processes for special education services provided free of charge under Free Appropriate Public Education requirements and Individuals with Disability Act. It is the responsibility of the school district to pay for those services that are determined to fall under the provisions of these laws.
BILLING	ARM 37.87.1802--The contract must include record keeping, management, billing procedures and must state which party is responsible for each requirement. Detailed instructions for CSCT billing are specified in ARM 37.87.1803, but these are not required to be written in the contract.	• The CSCT provider will submit Medicaid billing for CSCT reim-bursement under the school district Medicaid provider number. • The provider assumes all responsibility for Medicaid reimbursement and collection and request for payment denial appeals. • The CSCT provider bills third-party insurers and families following their fee schedule. All CSCT records maintained by CSCT provider will be available for review by appropriate school district personnel to verify billing activity upon request. • If Medicaid disputes any CSCT payments through audit or otherwise, the CSCT provider is obligated to repay Medicaid all such payments.
CRISIS RESPONSE	ARM 37.87.1802--CSCT contracts must specify the services to be provided. ARM 37.106.1956--CSCT programs must be able to provide direct crisis interven-tion services when student is in school (or school-operated facility) and a crisis plan that includes face-to-face encounters and telephonic, 24/7 responses. These services are not required to be written into the contract.	• The CSCT provider agrees to provide treatment, crisis management, and discharge planning services to enrolled CSCT children. • If available, the provider will assist school staff with a crisis situation related to students not enrolled in CSCT. • Outside school hours, the CSCT provider will direct students/families to the ER or provider agency protocol.

ELEMENT	COORESPONDING ARM REQUIREMENTS	EXAMPLE PROVISIONS IN EXISTING CONTRACTS
CSCT TEAM MEETINGS AND COORDINA-TION	ARM 37.87.1802-- In the contract, the school must identify the role of the school counselor and school psychologist in coordinating with CSCT and providing mental health services. Required coordination with other services, such as outpatient therapy and special education, is specified in ARM 37.106.1956, 37.87.1404, and 37.106.1965, but it is not required to be written into the contract. Mandatory meetings every 90 days with the CSCT supervisor and school are outlined in ARM 37.106.1956, but these meetings are not required to be written into the contract. The composition of the team that must be pres-ent to review the ITP every 90 days is speci-fied in ARM 37.106.1956 but not required to be included in the contract.	• The CSCT provider will develop and implement a plan of treatment in cooperation with the district for the child enrolled in CSCT services. The role of the school counselor and the school psychologist, as appropriate, will be identified in the provisions of the mental health services and supports to the youth, including coordination with the CSCT program. • The CSCT provider agrees to meet at least monthly with school district personnel regarding the IEP process, student evaluation, referral and recommendations, and mandatory or requested reports. • A member of the CSCT team must attend the IEP meeting when requested by the parent/legal guardian or the school. • The CSCT provider agrees to facilitate family involvement in treatment and discharge planning in the course of treatment.
SUMMER PROGRAM-MING	ARM 37.106.1956--CSCT services must be available 12 months of the year with a minimum of 16 hours per month during the summer months.	• The CSCT provider is responsible for all transportation for summer and other nonschool related days. • The provider will coordinate necessary summer services by a specified date with the school district each year. • The school agrees to provide adequate treatment space for group and individual therapy on nonschool days. *The contracts reviewed for this evaluation contained little to no information on the details of CSCT summer programming. Based on the ARM requirement and the feedback from stakeholders about confusion in this area, schools should review their contracts to better define CSCT summer services. Some CSCT providers offer full-time CSCT summer services and others only meet the minimum requirements. Schools should be aware of these differences in their contract negotiations.*
CASELOAD	Not specified in the ARM.	Caseload of 12 is recommended, but caseloads are not capped at this number.
EMPLOYEE BENEFITS	Not specified in the ARM.	Provider is an independent contractor, ineligible for employee benefits, and no payroll taxes are deducted.

ELEMENT	COORESPONDING ARM REQUIREMENTS	EXAMPLE PROVISIONS IN EXISTING CONTRACTS
CONFIDENTIAL- ITY AND REPORTING	ARM 37.87.1802--The contract should identify program data and information that will be shared between the school and mental health center to evaluate program effectiveness. Specific record requirements for CSCT are outlined in ARM 37.106.1961 but are not required to be in the contract.	• Each party holds in confidence. Neither use or disclose any nonpublic information without the express written consent of the other party. School district provides various data as requested by the provider (e.g., grades, attendance, and discipline). • The provider agrees to maintain clinical records and monthly progress reports, including service documentation sufficient to justify billings. All CSCT records maintained by the provider will be available for review by appropriate school district personnel or auditors. • The school agrees to provide various data as requested by the provider (e.g., grades, attendance, and discipline). The school district will provide student information as necessary. • The provider agrees to provide a summary report of the clinical records and progress reports to the school District on a quarterly basis. Reports must include services for CSCT eligible students and for those billed to third parties.
TRAINING	ARM 37.87.1802--In the contract, the school and mental health center must describe the annual training offered to school personnel, parents, and students related to (1) CSCT programs and services, (2) CSCT referral process and criteria, (3) signs and symptoms that indicate a need for mental health services, and (4) confidentiality requirements under FERPA, HIPAA, and HITECH.	School district provides annual training for staff, parents, and students with regard to the MBI structure, CSCT referral processes and goals will provide an annual list of all district professional development opportunities available to the Provider mental health staff. *The contracts reviewed for this evaluation contained limited information about training. Based on the ARM requirements, school districts should review their contract language to ensure that the training provisions are adequate.*
LOGISTICAL SUPPORT	ARM 37.87.1802--In the contract, the school must identify the following logistical supports: (1) Provision of transportation and classroom space during nonschool days as described in ARM 37.106.1956, (2) program supports, including telephone, computer access, locking file cabinets, and copying that the school will make available for CSCT staff, (3) office space that is adequate and appropriate for confidentiality and privacy, and (4) treatment space large enough to host a group during both school and nonschool days	• School district provides office space, private treatment space, phone, internet, printer access via the internet, computer access, copier access, and reasonable office supplies to support the provision of CSCT services. • District will not support contractor technology. • School district provides private office space that is sound-proof enough that conversations cannot be heard outside the walls of the office and treatment space large enough to host a group during school and nonschool days.

ELEMENT	COORESPONDING ARM REQUIREMENTS	EXAMPLE PROVISIONS IN EXISTING CONTRACTS
MBI/PBIS/ MTSS	ARM 37.87.1802--In the contract, the school must describe the implementation of school-wide PBIS, including, at minimum: (1) Identifying youth who exhibit inappropriate behaviors and need a PBIS plan and youth at risk of, or suspected to have need of, mental health services, (2) Implementing and monitoring the progress of a PBIS plan for effectiveness, and (3) referring youth to the CSCT program when PBIS have not resulted in behavior change and when the youth may have a clinical condition that needs to be addressed.	The school district will implement, assess, and monitor a school-wide positive behavior intervention plan for all students, including students at risk or suspected to have need of mental health services. Referral to the provider will be according to the plan. *The contracts reviewed for this evaluation contained limited language about the use of PBIS, particularly related to implementing and monitoring a PBIS plan for effectiveness and the link between PBIS and referral to CSCT. Based on the ARM requirements, school districts should review their contract language to ensure that PBIS provisions are adequate.*

FACILITATE COMMUNICATION WHILE RESPECTING CONFIDENTIALITY

As schools and mental health centers coordinate to operate CSCT programs, it is important that stakeholders maintain open channels of communication while taking steps to protect student confidentiality. The primary federal laws that cover student and patient confidentiality are FERPA, HIPAA, HITECH. For specific questions related to the case-by-case application of these laws in local districts, schools, and CSCT providers, consult the organization's legal counsel for advice.

The table below defines each law and broadly describes the implications of the law for CSCT programs.

STATUTE	APPLIES TO	IMPLICATIONS FOR CSCT
HIPAA	HIPAA Administrative Simplification Rules (see 45 CFR Parts 160, 162, and 164), apply to "covered entities," and "Health care providers," including CSCT Mental Health Center providers. The HIPAA Privacy Rule requires covered entities to protect individuals' health records and other identifiable health information by requiring appropriate safeguards to protect privacy and setting limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections.	The CSCT Mental Health Center provider is subject to HIPAA. In general, schools are not bound by HIPAA unless they directly employ a healthcare provider that is billing electronically. Under the privacy rule, a covered entity is permitted to use and disclose Protected Health Information (PHI) without an individual's authorization for treatment, payment, and healthcare activities like quality assessment or evaluations.
FERPA	FERPA is a federal law that protects the privacy of students' education records (see 20 U.S.C. § 1232g; 34 CFR Part 99). FERPA applies to educational agencies and institutions that receive funds under any program administered by the U.S. Department of Education. Health records maintained by school nurses or counselors fall under FERPA, not HIPAA. FERPA grants parents and eligible students the right to review the student's education records maintained by the school and request correction of records they believe to be inaccurate or misleading.	FERPA allows sharing of student's Personally Identifiable Information, including health and medical records held by the school to third parties with written parental consent or, under specific circumstances (e.g., if schools have a "legitimate educational interest" in accordance with school policy or in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals). Verbal sharing of student information in order to support a student in crisis or receiving a CSCT ITP within a school's MBI problem-solving team should generally be allowed under FERPA.
HITECH	HITECH was enacted as part of the American Recovery and Reinvestment Act of 2009 to promote the adoption and meaningful use of health information technology. HITECH expanded on HIPAA to strengthen an individual's right to receive an electronic copy of his or her PHI and broadened the definition of business associate of a covered entity.	The law does not have broad implications for CSCT except as an extension of the provisions that the CSCT provider must adhere to for HIPAA.

COMMUNICATION AND CONFIDENTIALITY CONTINUED

For more information on HIPAA and FERPA, see the joint guidance on application of HIPAA and FERPA to student health records published jointly in November 2008 by the U.S. Department of [Education and the Department of Health and Human Services.](#)

Because these federal laws are so complex and individual student situations within schools have unique nuances, CSCT programs report a range of challenges arising from misunderstandings and applications of HIPAA, HITECH, and FERPA in local school districts. Some CSCT providers who provided feedback for this evaluation reported being banned from serving on MBI problem-solving teams by administrators because of privacy concerns. Others noted that they have been told by CSCT program administrators not to share relevant student information with school counselors, nurses, or teachers. Jenny Wallace, a former employee of the Helena Public School District who worked extensively to understand how to facilitate open communication between CSCT providers, schools, and other community stakeholders, believes that these laws do not prohibit sharing of relevant information between CSCT teams and schools staff in the context of developing tiered behavioral supports for students under the CSCT contract. She notes, "HIPPA does not apply to schools and FERPA applies to written student records. The CSCT contract is an agreement that allows the CSCT provider to share health information with the school and vice versa." Ms. Wallace believes that problem-solving teams should include as many school and CSCT stakeholders as possible, including school nurses, counselors, school staff, and the CSCT team. She explains, "You really have to have everyone on that team. In our district, there was a student brought to the team who was normally a great student, but suddenly everything was falling apart. The A-Team spent weeks trying to understand what was happening until the school nurse attended a meeting. Right away she said, 'Oh this

student is on thyroid medication. It sounds like she needs a medication adjustment.' And everything was solved. The students being supported through CSCT have very complex health needs. So we need to let people be experts in their own area, and we need as many people as possible at the table. It is dangerous to have professionals attempting to cover subject areas they are not experts in, especially when lives are at stake. These laws should not be thrown up as barriers to effectively supporting kids."

Several of the contracts reviewed for this application included provisions related to HIPAA and FERPA. The contract language was often fairly restrictive in terms of information sharing. For example, one district's contract included the following provisions.

- The CSCT provider recognizes that the school district is not a healthcare organization. The CSCT provider is a covered entity required to comply with HIPAA and HITECH federal regulations. To disclose information to the district, the CSCT provider will require a release of information to be authorized for each client receiving CSCT services. The CSCT provider reserves the right to withhold information defined as PHI in 45 CFR 160.103 if a request compromises the ability for the provider to remain compliant with HIPAA and HITECH federal regulations.

- The school district agrees to protect the privacy of clients by limiting the discussion and disclosure of client information related to services provided by the CSCT provider to the minimum personnel necessary. School district agrees to notify the CSCT provider in a timely fashion of any potential or known unauthorized disclosures. If the school district requires collection and retention of records containing PHI outside of the CSCT provider's services, a business associate agreement may become necessary.

COMMUNICATION AND CONFIDENTIALITY CONTINUED

Jenny Wallace acknowledges the complexities of understanding these laws for school districts. "Policies about information sharing must be developed at the local level with the help of legal counsel in the school districts, but it is very hard to find experts who understand FERPA, HIPAA and 42CFR, especially in more rural areas." She recommends that the OPI, DPHHS, the School Administrators of Montana, or other state-level entities provide guidance to schools in Montana on this issue to help them create effective programs with open models of communication while following both state and federal statute. The state could also provide clarity on the state ARM requirements for care coordination between the school, CSCT provider, and outpatient therapy and how schools can meet these requirements in

compliancewith HIPAA, FERPA, and 42CFR. Jenny Wallace argues, "The state ARM requires information sharing between the school, CSCT provider, and community-based treatment. These ARM's are not in violation of federal statute. It would be helpful if a state entity put this in writing for local school districts to avoid confusion."

The OPI has recently developed online training titled "Training Guidance for HIPAA and FERPA for Schools" that will be available on the Hub in February or March of 2018. A HIPAA and FERPA Comparison Tool developed by SAMHSA and Project AWARE is included in Appendix IV.

PROVIDE ONGOING TRAINING FOR SCHOOL AND CSCT STAFF

As mentioned in previous sections of this report, the CSCT stakeholders who provided feedback for this evaluation indicated that the training provided for CSCT teams is often not adequate to meet their needs. In the electronic survey results, one in four CSCT team members rate their "access to training and support for CSCT and school staff" as fair or poor. One former CSCT provider interviewed for this evaluation noted, "The training offered through our CSCT provider was mediocre at best. They would meet the minimum requirements for 18 hours of continuing education, but a lot of the training was not high quality and was designed to only meet the bare minimum requirements, not

advance our practice. They would not pay for additional trainings beyond what was offered, so I tried my best to take advantage of any free training." Other providers reported using their own money to gain access to important trainings, such as how to implement trauma-informed approaches. More could be done to support CSCT providers to access needed trainings.

As mentioned above, the ARM has a number of specific provisions related to training for CSCT, including annual training for all stakeholders and specific training for CSCT staff.

TRAINING FOR ALL STAKEHOLDERS	TRAINING FOR CSCT STAFF
In the contract, the school and mental health center must describe the annual training offered to school personnel, parents, and students related to: • CSCT programs and services. • CSCT referral process and criteria. • Signs and symptoms that indicate a need for mental health services. • Confidentiality requirements under the FERPA, HIPAA, and HITECH.	The CSCT staff are required to receive 18 hours of training per year in behavior management strategies that focus on the prevention of behavior problems for youth with SED. Training must include: • Positive behavioral intervention planning and support. • Classroom and youth behavior management techniques that include certified de-escalation training inclusive of physical andnonphysical methods. • Evidence and research-based behavior interventions and practices. • Progress monitoring techniques to inform treatment decision.

TRAINING CONTINUED

To improve access to training for CSCT providers and school staff statewide, the OPI has developed a variety of online trainings through the Hub that are relevant to CSCT and available free of charge to all school staff and CSCT providers. A number of these trainings are newly developed and are set to release in the coming months including:

- Overcoming ACE's In Montana Schools: Childhood Trauma and Its Impact on Learning--to be released January of February 2018.

- Overview of Youth Suicide--to be released in February or March 2018.

- Suicide Prevention Strategies for Schools--to be released in February or March 2018.

- Suicide Prevention Protocols for Schools--to be released in February or March 2018.

- Training Guidance for HIPAA and FERPA for Schools--to be released in February or March 2018.

Visit the Hub to view the current course catalog.

In terms of developing adequate training systems at the local level, school districts should first review their training requirements as specified in their contracts. As is noted in the contract section above, it appears that the training provisions outlined in some existing contracts are not adequate to meet the ARM requirements. In addition, schools districts and providers should have ongoing conversations about their plan for implementing CSCT trainings each year. Questions that should guide these conversations include:

- How will we prioritize training topics for our CSCT staff, school administrators, school staff, parents, and students?

- Who will be responsible for selecting and implementing trainings?

- How are we ensuring that the trainings provided are based on the best available evidence for behavioral and therapeutic interventions for students?

- When and how will the training be scheduled?

- What is the training budget?

- How will the training be publicized?

- How will we evaluate the effectiveness of our training?

- Does our training plan meet the training requirements as specified in the ARM?

As is recommended in the expectations section above, the more clarity that can be prescribed around these expectations, the better. This may include developing a signed, written training plan or agreement between the CSCT provider and school.

QUESTIONS TO GUIDE CSCT TRAINING CONVERSATIONS

OTHER RECOMMENDATIONS

Beyond the above recommendations for making CSCT programs more evidence-based and data driven, a number of additional themes arose from the stakeholders surveyed and interviewed for this project for improving the implementation of CSCT on the ground.

EMBED CSCT INTO THE SCHOOL CULTURE WITH HIGHLY VISIBLE TEAMS THAT FOSTER SCHOOL STAFF BUY-IN

Repeatedly CSCT stakeholders underscored the importance having CSCT teams embedded into the school culture. "CSCT teams that work to integrate themselves into their school cultures are generally very successful in areas of communication and collaboration," explains one CSCT team member. Another school administrator notes, "The key is the relationship between the principal, the school counselor, staff, and the CSCT team: emotionally and academically, socially, behaviorally. The CSCT team in the building has to embrace the school culture; not just acting as a separate agency with the school. The best scenario is when the therapists and behavioral aides are in the classrooms as much as possible. It can't be 'you are CSCT and we are the school.'

CSCT should be building relationships with all of the school staff by being present and visible."

One administrator emphasized that this process takes effort from all parties. He recommends that schools "take the time to build relationships and include the CSCT staff in your building culture, including staff meetings and social gatherings. Create understanding and support between school staff and CSCT staff. They need each other to help the student and family. Create opportunities for the CSCT staff to be involved in the school community where they can be seen by other students and staff so they become part of the school."

HIRE STAFF THAT WILL FIT WELL INTO YOUR SCHOOL CULTURE

Administrators repeatedly emphasized the paramount importance of hiring CSCT staff who integrate effectively with the school culture and go the extra mile to serve students. Including school staff in the CSCT hiring process helps facilitate effective hiring. Lisa Lowney, an elementary principal in Helena, notes, "We had trouble finding therapists for the first few years. It was hard to find a good fit. So I became adamant that we, as the school building administration, needed to be involved in the interview process. We put this requirement into our contract. When we were allowed to interview the CSCT applicants, I would ask them questions about school culture and building culture. When we

started participating in interviews as a school district, there was only one time when we hired a therapist and it just wasn't a good fit." Other stakeholders echoed these sentiments, saying that CSCT is most successful when the right staff are hired who are passionate about working with students and willing to participate fully in the life and culture of the school. One counselor put it succinctly. "Hire amazing people, let them work and build relationships, and then work really hard to keep them even though they can make more money in private practice."

FACILITATE REGULAR TEAM MEETINGS

To successfully embed CSCT into the school culture, many stakeholders recommended regular multi-stakeholder team meetings, including problem-solving and grade-level meetings to address student behaviors within a MTSS/MBI model. These meetings are essential to facilitate communication between the school and CSCT team and to ensure that referrals to CSCT are appropriate. School counselors seemed to particularly underscore the importance of these team meetings for helping connect CSCT and other school mental health services. "I think meeting with the problem-solving Tier III team and working together to decide on ranking is helpful. Sometimes the building team has knowledge about a child that can be helpful, and what CSCT brings to the meetings is also helpful when developing a plan for students." Another said, "Making sure that the school administration meets frequently with the CSCT staff to discuss students and goals is necessary. I also believe that team meetings that include the counselors, school psychologists, teachers, administration, and CSCT staff help to develop a more cohesive team approach for supporting students. In general, accountability is important."

USE CSCT TO SUPPORT ACADEMIC SUCCESS

Another key that several stakeholders discussed was working with teachers to understand the importance of CSCT and ensure that the CSCT services do not interfere with academic instruction. One behavioral health aide described how her CSCT team worked to schedule CSCT supports in ways that did not interrupt important classroom instruction. "We do not schedule individual CSCT therapy times during the morning to support teachers. But we go to the teachers personally and talk about our goals with the student and coordinate with them. If we have someone who is in crisis, the student might come into our office for de-escalation, but we make sure that it isn't treated as a reward that causes students to want to leave class." The behavioral aid also stressed the importance of providing coaching to teachers to support behavioral interventions in the classroom. "When you come up with a behavior plan for a student and you communicate it, teachers don't remember. They have too much on their plate. We have to teach and reteach to best support them in the classroom."

PROACTIVELY ENGAGE FAMILIES

Engaging families was one key to CSCT program success outlined by many stakeholders. One principal described the intense efforts required to engage some families: "CSCT works best when you have therapists who will go any distance to reach out to parents and support them for the benefit of the child. In general, therapists really worked hard to get parents involved." One key to engaging parents is to ensure their involvement is an explicit expectation for participation in CSCT. Kim Chouinard from Yellowstone Girls and Boys Ranch describes her organization's expectation-setting process with families this way: "In our intake procedure for new families, we clearly communicate that they are expected to be a part of the child's treatment team. We have written expectations that they sign when their child gets admitted into our services. The expectations list is parent-friendly and gives a quick snapshot of 'this is what the therapist does, this is what the behavioral specialist does.' Once the relationship is built and they understand our expectations, then it is pretty smooth sailing."

IMPROVE CSCT SUPERVISION

CSCT programs can be strengthened by improving the presence and quality of supervision for CSCT. Chouinard, of the Yellowstone Boys and Girls Ranch, notes that visibility in the school is important, not only for the CSCT team but for the CSCT supervisor. "The key to successful programs is the relationship both on the CSCT teams level and supervisor level. Schools need to know that your CSCT program is accountable and has an effective supervisory structure. We are very proactive in building that relationship and educating the schools."

Both the school and the individual CSCT teams need ongoing, ready access to the CSCT supervisor. Unfortunately, some CSCT members reported having difficulty accessing their CSCT supervisor for questions and feedback, especially during the onboarding process for new hires. This was especially true for CSCT staff working at rural schools far from the physical location of the CSCT provider. One school administrator noted, "CSCT

supervisors need to train new staff better and not leave them to 'figure it out' on their own when setting up programs. The key is to communicate and network with school staff daily." School districts should review the provisions for supervision for CSCT staff included in their contracts and consider strengthening these provisions as necessary.

CSCT staff also noted the need to have more positive feedback from supervisors. One recommended that CSCT providers "encourage supervisors to provide positive feedback to CSCT employees to boost employee morale as this job is stressful and emotionally draining." CSCT providers should assess the level and model of supervision currently provided to their CSCT staff and consider how to best support and provide feedback to their providers in effective and tangible ways, especially for staff working in remote areas.

ENCOURAGE SYSTEMATIC DATA COLLECTION

Finally, CSCT programs should be encouraged to systematically gather data to track student outcomes, inform the treatment planning process, and monitor the fidelity of implemented interventions.

As the ISF model emphasizes, effective school mental health and PBIS partnerships should utilize data-driven decision making and rigorous progress-monitoring to track fidelity and effectiveness.[20]

Data collection should occur at both the individual and systems levels. For individuals referred to CSCT, schools should utilize standardized assessment tools like FBAs that systematically assess behavior and support the development of data-driven ITPs. Schools should then track data on the behavioral interventions implemented through the student's ITP, the result of these interventions, and short- and long-term behavioral and academic outcomes. This data should be utilized by the problem-solving and CSCT treatment team to update the student's ITP over time.

At the systems level, schools should collect data to monitor their implementation of MBI and CSCT according to best practices. Many schools in Montana already utilize the University of Oregon's online School Wide Information System (SWIS) tracking tool to monitor their implementation of MBI. Of the approximately 150 schools in Montana that used theTiered Fidelity Inventory to monitor their implementation of support through the PBIS applications, schools averaged 79.3 percent of the possible points for Tier I, 45.4 percent of the points for Tier II and 30.4 percent of the possible points for Tier III supports in the 2016-17 school year.[21] As these data show, fidelity to Tiers II and III is a concern for many schools implementing MBI. Not all schools implementing MBI are entering data into the SWIS system. More could be done to monitor fidelity and increase implementation of Tier II and III supports in the state.

ENCOURAGE SYSTEMATIC DATA COLLECTION CONTINUED

Other free, validated tools like the OSEP PBIS Technical Assistance Center's Tiered Fidelity Inventory[22] and the PBIS Self-Assessment Survey[23] could be used by schools to evaluate the effectiveness of their school's MBI and CSCT implementation and fidelity to the model. The Tiered Fidelity Inventory is a free tool developed by the OSEP PBIS Technical Assistance Center. The tool describes the research-based elements of comprehensive Tier I, II, and III interventions and allows schools to evaluate their use of each of these elements. The PBIS Self-Assessment Survey can be used by school staff for initial and annual assessment of effective behavior support systems in their school. The survey examines the status and need for improvement of four behavior support systems: (1) school-wide discipline systems, (2) non-classroom management systems (e.g., cafeteria, hallway, playground), (3) classroom management systems, and (4) systems for individual students engaging in chronic problem behaviors.

CONCLUSION

Many schools in Montana are effectively implementing school mental health services within a multitiered system of support for their students with SED through the CSCT program. However, based on research findings and feedback from local, state, and national stakeholders, many CSCT programs could be strengthened in a number of critical ways to incorporate evidence-based practices at both the individual and school systems levels. This evaluation made clear that CSCT has many committed and knowledgeable champions in school districts statewide who are willing local partners for the OPI, DPHHS, and the state management team. These local partners are highly invested in making the CSCT program as effective and impactful as possible in their local districts. The state should continue to solicit and incorporate their input as they develop guidance, requirements, and support for CSCT.

"CSCT PARTNERS ARE HIGHLY INVESTED IN MAKING THE PROGRAM AS EFFECTIVE AND IMPACTFUL IN LOCAL DISTRICTS."

FUNCTIONAL BEHAVIORAL ANALYSIS AND ITP PLANNING TOOL EXAMPLES FROM HAMILTON MIDDLE SCHOOL

Problem Behavior Pathway – "Analysis of the Problem Behavior"

Student: _____ Grade: _____ School: _____ Date: _____

Problem Routine: _____ Time of Day: _____

SETTING EVENTS "The Slow Triggers" ASK: What events "set the stage" for the problem behavior?	TRIGGERING ANTECEDANTS "The Fast Triggers" ASK: What events immediately, within seconds, precede the problem behavior?	PROBLEM BEHAVIOR "What does the problem behavior look like?" ASK: What specifically does the problem behavior look/sound like?	MAINTAINING FUNCTION/CONSEQUENCE "Why does the behavior keep happening?" ASK: Does the student engage in the problem behavior in order to: GET DESIRED: _____Adult Attention _____Peer Attention _____Access to a Task/Activity _____Sensory Stimulation OR GET AWAY FROM UNWANTED: _____Adult Attention _____Peer Attention _____Tasks/Activities _____Sensory Stimulation

COMPETING BEHAVIOR PATHWAY -- "BUILDING BEHAVIOR SUPPORT"

Student:_____ Grade:_____ School:_____Date: _____

Setting Events "Slow Triggers"	Triggering Antecedents "Fast Triggers"	Problem Behavior	Maintaining Function/Consequence "The student engages in the problem behavior in order to: GET… OR GET AWAY FROM…"
Setting Event Interventions – Prevent the problem behavior "Strategies to reduce the occurrence/impact of the setting events."	**Triggering Antecedent Interventions –** Prevent the problem behavior "Strategies to reduce the occurrence/impact of the triggering antecedent."	**Replacement Behavior Interventions –** Make the problem behavior unnecessary "Skills/behavior/response we will teach the student to do instead."	**Managing the Maintaining Function/Consequence -** Encourage Positive Behavior Desired reinforcers to deliver after the student engages in the desired or replacement behavior: Discourage Problem Behavior Negative consequences to deliver after the student engages in the problem behavior:

Problem Behavior Pathway

Student: ___Fake student _John D._____   Grade: __4th__   School: _Tucker Creek Elementary_   Date: __10/6__

Time: _10:15 – 10:30 a.m._   Setting: _Recess_____

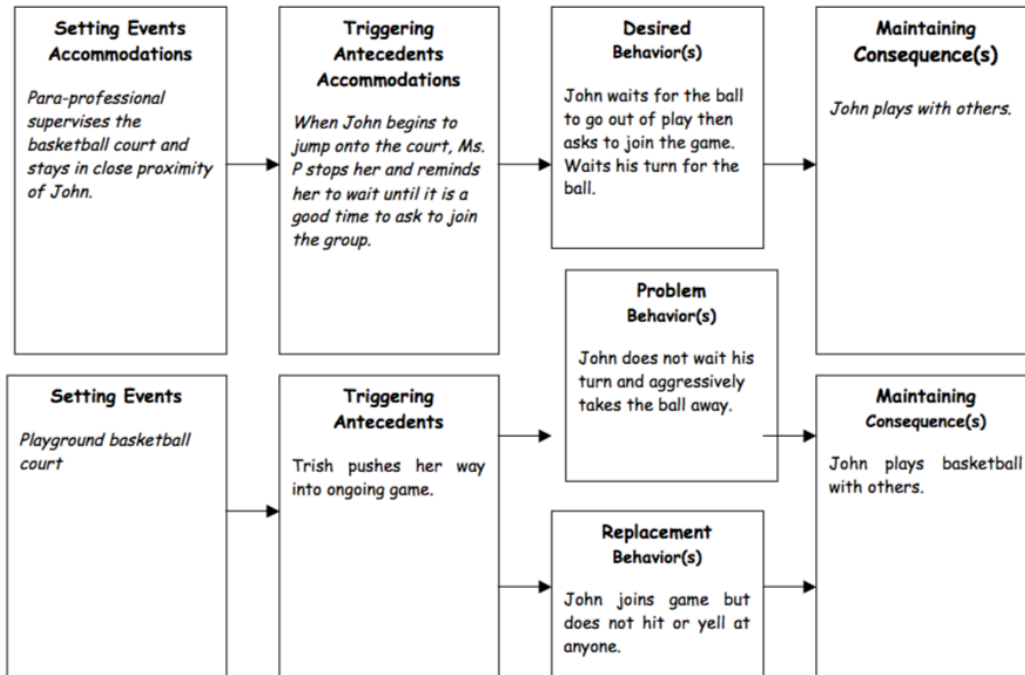| Setting Events	Triggering Antecedents	Problem Behavior(s)	Maintaining Consequences
Playground free play	→ *Trish sees Marsha with the class football and decides playing catch with her friend Rae would be fund.*	→ *Trish approaches Marsha and says, "Give me the football." Marsha says "no," so Trish yanks the ball from Marsha and shoves her to the ground.*	→ *Trish gets the ball and finds Rae. They play catch until the bell rings to return to class. Marsha goes and sits alone on a swing, too afraid to tell the playground supervisor what happened.*

FUNCTIONAL BEHAVIORAL ANALYSIS AND ITP PLANNING TOOL EXAMPLES FROM HAMILTON MIDDLE SCHOOL CONTINUED

COMPETING BEHAVIOR PATHWAY

Student: __John D__   Grade: __4__   School: __Tucker Creek__   Date: __10/3__

Setting Events Accommodations

Para-professional supervises the basketball court and stays in close proximity of John.

Triggering Antecedents Accommodations

When John begins to jump onto the court, Ms. P stops her and reminds her to wait until it is a good time to ask to join the group.

Desired Behavior(s)

John waits for the ball to go out of play then asks to join the game. Waits his turn for the ball.

Maintaining Consequence(s)

John plays with others.

Problem Behavior(s)

John does not wait his turn and aggressively takes the ball away.

Setting Events

Playground basketball court

Triggering Antecedents

Trish pushes her way into ongoing game.

Maintaining Consequence(s)

John plays basketball with others.

Replacement Behavior(s)

John joins game but does not hit or yell at anyone.

COMPETING BEHAVIOR PATHWAY

Student: __Fake student Maurice R.__ Grade: __5__   School: __Kingston Elem.__   Date: __2/9__

Setting Events Accommodations

group-individualized instruction in mixed ability teams with Ms. Hayes working with teams

Triggering Antecedents Accommodations

students assigned to teams & given group-individualized assignments & roving assistants.

Desired Behavior(s)

Maurice complies by working with classmate & asking for assistance.

Maintaining Consequence(s)

Ms. Hayes praises Maurice for correct responses & for asking appropriately for help.

Problem Behavior(s)

Maurice becomes angry & disrupts class by tantruming.

Setting Events

whole group instruction-Ms. Hayes puts several problems on board & works with class.

Triggering Antecedents

Ms. Hayes asks class to begin work on worksheet on fractions.

Maintaining Consequence(s)

Maurice gets out of doing worksheet on fractions.

Replacement Behavior(s)

Maurice expresses frustration to Ms. Hayes.

FUNCTIONAL BEHAVIORAL ANALYSIS AND ITP PLANNING TOOL EXAMPLES FROM HAMILTON MIDDLE SCHOOL CONTINUED

COMPETING PATHWAYS

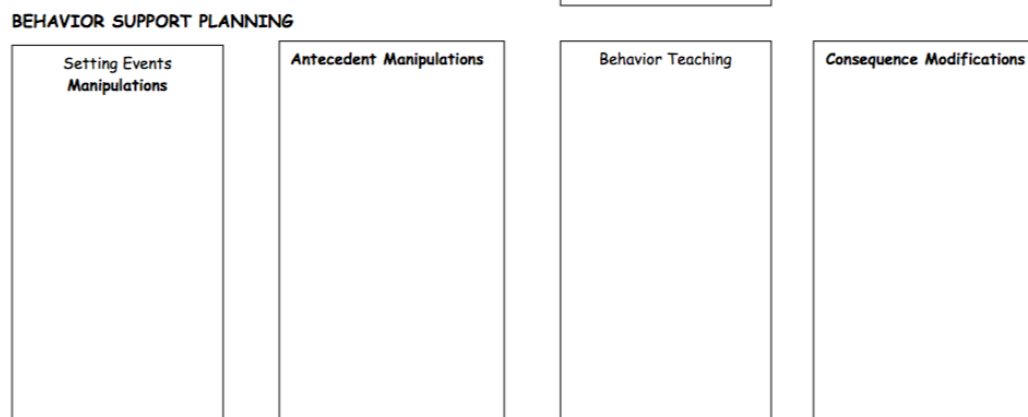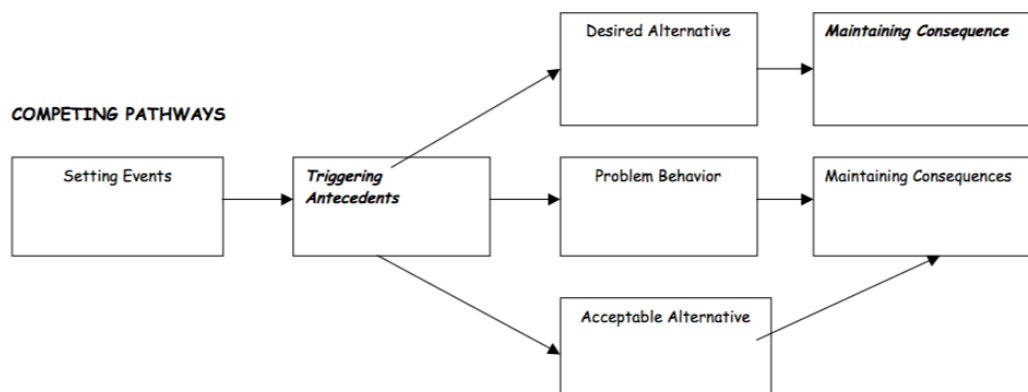|		Desired Alternative	→	*Maintaining Consequence*

Setting Events	→	*Triggering Antecedents*	→	Problem Behavior	→	Maintaining Consequences

			Acceptable Alternative	

BEHAVIOR SUPPORT PLANNING

Setting Events Manipulations	Antecedent Manipulations	Behavior Teaching	Consequence Modifications

Building a Support Plan

		Desired Behavior		Consequence

Setting Events	Predictors	Problem Behavior		

		Replacement Behavior		Maintaining Consequence

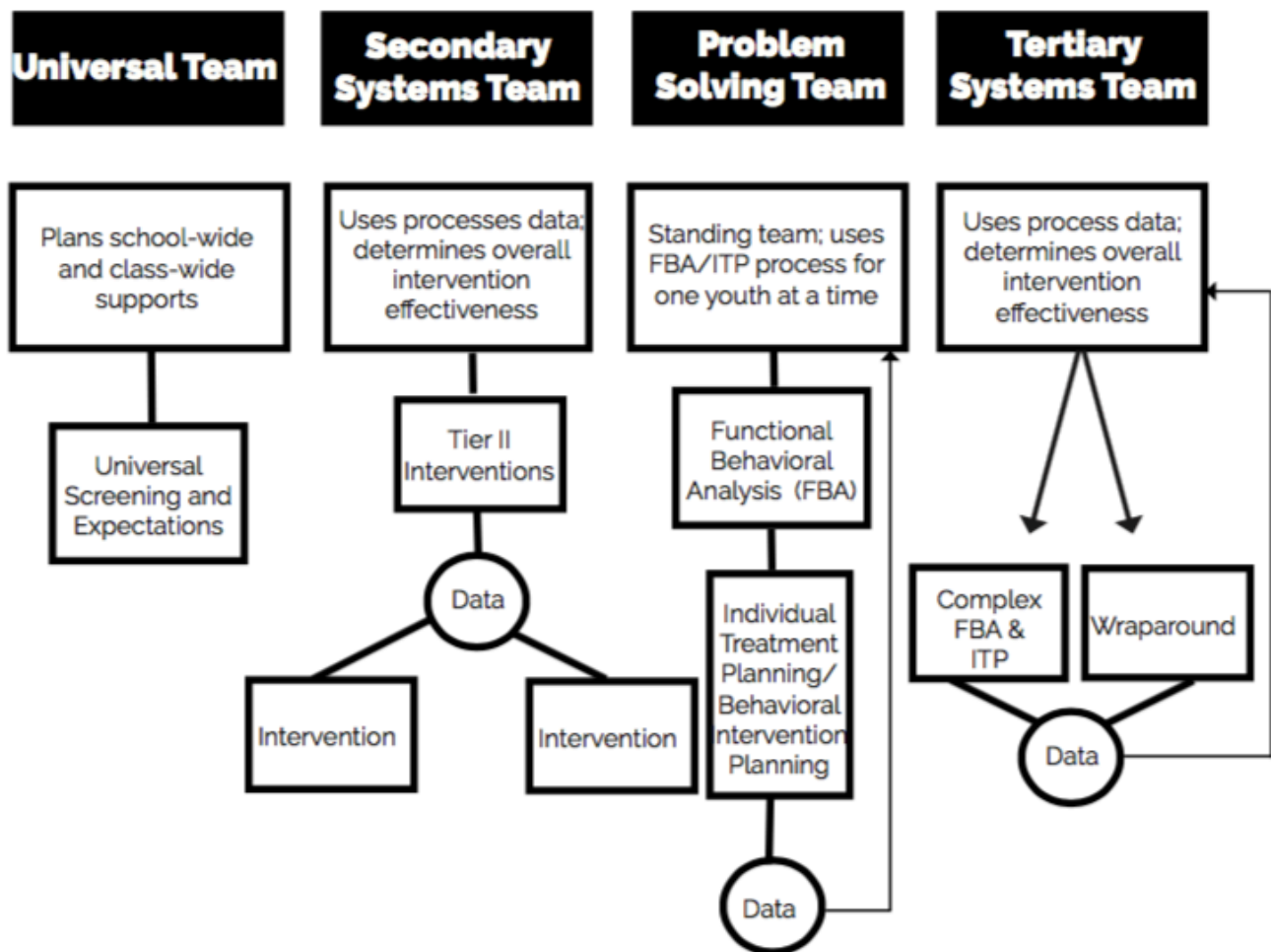| What are ways to change the context to make the problem behavior unnecessary?	What are ways to prevent the problem behavior?	What can be done to increase expected behaviors or to teach a replacement behavior?	What should happen when a problem behavior occurs?	What should happen when desired or replacement behavior occurs?
___Clarify rules and expected behavior for whole class ___Written contract with the students ___Student self-manipulator sheet ___Change seating arrangements ___Change schedule ___Counseling ___Other	___Reminders about behavior when problem behavior is likely ___Provide extra assistance ___Modify assignments to match student skills ___Other	___Practice expected behavior in class ___Self-management program ___Other	___Reward/ punishment program ___Contact with parents ___Reduced privileges ___Time out ___Office referral ___Reprimand in class ___Other	___Reward program? ___Praise from teacher ___Other

APPENDIX II

Schools nationwide often have tiered problem-solving teams who are responsible for implementing the various aspects of PBIS, including Tier III ITPs and wraparound interventions. For smaller schools in Montana, the system of problem-solving teams may be more simplified.

Three Tiered System of Support with Problem Solving Teams National Example

Universal Team	Secondary Systems Team	Problem Solving Team	Tertiary Systems Team
Plans school-wide and class-wide supports	Uses processes data; determines overall intervention effectiveness	Standing team; uses FBA/ITP process for one youth at a time	Uses process data; determines overall intervention effectiveness

Universal Screening and Expectations

Tier II Interventions → Data → Intervention / Intervention

Functional Behavioral Analysis (FBA) → Individual Treatment Planning/ Behavioral Intervention Planning → Data

Complex FBA & ITP / Wraparound → Data

Source: Adapted from an example from Wisconsin located here:
http://www.pbis.org/Common/Cms/files/Forum16_Presentations/A16_Saladis_et_al.pdf

CSCT REFERRAL FLOWCHART EXAMPLES CONTINUED

This example schematic below from the Helena Public Schools depicts the use of one, centralized problem-solving team within a MTSS for referral to CSCT. This model is more realistic for Montana districts, especially in more rural and frontier schools.

Helena Public School's CSCT Referral Chart

Concern based on based on observable behavior

↓

A-Team (Problem Solving Team) Meeting (includes CSCT building staff)
- A-Team reviews history of concern
- Brainstorms Tier II Interventions based on measurable goals
- A-Team coordinator logs goal, Tier II interventions, follow-up date for review
- Process continues until resolution of concern is reached or elevated to Tier III status

↓

Tier III Interventions

When Tier III interventions are discussed and CSCT referral is chosen by the A-Team:
- Referral made via consented referral system by A-Team Coordinator
- When an opening in the CSCT caseload is determined to be imminent, the A-Team, to include CSCT staff, will review the current waitlist, based on sequential order and priority, and establish the next student offered services. All referals to CSCT referrals must include verbal consent from parent/guardian

↓

CSCT obtains consent to assess

→ Student qualifies → CSCT services offered → Services accepted → Medicaid eligible → Enrolled in CSCT

Student does not qualifiy → Re-directed to the A-Team to make or review provisional plan

Provisional plan:
Made with A-Team and family
- Referral to community based services provider
- Documentation of parents' decline of services/referrals

Family declines ← Private insurance or self pay

Family agrees to pay co-pay or behavioral specialist fee-sliding fee scale offered → Enrolled in CSCT

APPENDIX III
EXAMPLES OF EXPECTATION-SETTING DOCUMENTS

■ HANDOUT FOR TEACHERS: WHAT TO EXPECT FROM CSCT

CSCT is a partnership between <Mental Health Center provider> and your school to provide specialized mental health services to students and their families. <The CSCT provider> is a licensed mental health center. Our partnership involves <CSCT provider> hiring mental health staff, including a master's level program therapist and a bachelor's or equivalent level behavior specialist.

WHAT DOES THIS MEAN FOR YOU AS AN EDUCATOR?
<The CSCT Provider> and your school have agreed to house a therapist and behavior specialist in your school. CSCT has a smaller caseload, averaging 10-15 students compared to a school counselor, who is sometimes responsible for hundreds of students. They work directly in the classroom and sometimes need to schedule times outside of the classroom for individual and group therapy.

The CSCT therapist offers individual, group, and family therapy to address more in-depth and intensive issues with your students to meet their social/emotional/behavioral needs that may be affecting the classroom, school, and home or community environment. The therapist will work with the student's teacher(s) to identify appropriate times to meet with the student. There may be times when the therapist helps the student within the classroom setting. Therapists are not tutors nor may they offer educational assistance to students.

The behavior specialist works with school staff to identify areas where a student needs more support. Perhaps a teacher has a student who struggles during reading or math. The teacher may recognize that if this student has additional structure from the behavior specialist, the student will be successful. A student may struggle at recess or during lunch, the <CSCT provider> staff can work this time into their schedule and offer support during these unstructured times, such as modeling and teaching coping skills to the youth. Behavior specialists are not tutors nor may they offer educational assistance to clients. Their role is to provide social, emotional and behavioral guidance, and structure.

WHAT ARE THE BENEFITS TO HAVING CSCT IN YOUR SCHOOL?
The therapist and behavior specialist are trained to work with students who have emotional disturbances. The benefit of these two staff being in your school is the additional support for teachers, paraprofessionals, and students.

The intention of school-based services is to provide mental health support to youth during the school day in the school setting. Often, these students are pulled out of school to see outpatient therapists or other mental health professionals. By utilizing school based services, attendance often increases, and students engagement in mental health services often increases, as does family involvement at school.

WHAT DO CSCT TEAMS NEED FROM SCHOOL PERSONNEL?

School-based staff need *referrals* from teachers, principals, school counselors, paraprofessionals, and other school staff. *You* are the experts from whom students need additional support. School-based staff rely on these referrals to identify the students most in need of mental health services.

School-based staff need a *teamwork* approach. As mental health workers, school-based staff are required to complete quarterly treatment plans for each student on their caseload. They will be asking for your input and need your willingness to offer support. This relationship is reciprocal. A teacher may want additional input on how to work with an identified student. School-based staff are willing to give feedback and help in brainstorming ideas on how to best address student's needs. Additionally, school-based staff need access to the identified students for in-class intervention as well as for pull-out services when needed.

HOW DOES A CHILD QUALIFTY FOR CSCT?

There are two qualifying factors for this program: meeting SED criteria and a funding source. School-based staff are trained to determine these two factors. Once a student is referred for services, <CSCT provider staff> work with parents and guardians to determine eligibility.

Students that are determined to be SED by the CSCT therapist in mental health terms qualify for services. Students do not have to be identified as meeting the requirements for special education services to receive these services.

Students on Medicaid are financially eligible for school-based services. Medicaid funding ensures the student will be able to have therapist and behavior specialist services. In addition, our staff follows up on any private insurance benefits or HMK/CHIP (Children's Health Insurance Plan) that may be available to pay for services. Staff also offers a sliding-fee scale to parents who may be interested in services but do not have any insurance benefits. Please know that most private insurance policies will only pay for the program therapist services and, often times, behavior specialist services are not covered.

DO SCHOOLS PAY FOR CSCT TO BE ONSITE?

Schools do not pay a direct cost for CSCT staff to be in the school. However, there are in-direct costs.

EXAMPLES OF EXPECTATION-SETTING DOCUMENTS CONTINUED

■ HANDOUT FOR PARENTS: EXPECTATIONS FOR PROGRAM PARTICIPATION

Thank you for allowing us the opportunity to work with you and your child. Your child will receive maximum benefits from our services if we are able to form an on-going, collaborative relationship with you as the parent/guardian. The following is a summary of what we will need from you to provide the best possible services to your child.

CSCT provides services to youth and their families 12 months per year. This includes a summer program to ensure that skills learned and progress made during the school are not lost over the course of an extended break. The summer program allows for continued attention and focus on the therapeutic relationship, youth's progress, and presenting issues and relevant family dynamics throughout the year.

The CSCT program has a specific set of rules and regulations from the State of Montana. With these regulations comes the need to have paperwork reviewed and approved by the parent/guardian on a regular basis. Examples of these expectations are:

- Quarterly review and update of the youth's individualized treatment plan with the parent's/guardian's signature.

- Semi-annual review and re-authorization of releases of information documents.

- Monthly participation in discussions regarding the progress your child is making on their individualized treatment plan.

- Participation in annual clinical assessment updates to determine your child's eligibility for the CSCT program.

- Participation in family therapy is encouraged to promote consistency across the school/home/community settings.

To avoid out-of-pocket expenses, information regarding changes in youth insurance coverage should be communicated to the CSCT team as soon as you are aware of those changes.

Information regarding other service providers must be communicated to the CSCT team, such as outpatient therapist, case managers, youth mentors, and/or treatment managers. This is to insure coordination of services and treatment plan focus. Medicaid requires coordination between CSCT, home support services, and outpatient therapists.

 I have read and understand the Expectations of Program Participation and agree to participate accordingly for the benefit of my child.

Parent/Guardian: _____ Date: _____

APPENDIX IV

HIPAA AND FERPA COMPARISION TOOL

HIPAA AND FERPA COMPARISON TOOL

Guiding Question or Key Aspect	HIPAA	FERPA
What is it? What are the general requirements?	The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule is a federal law that protects the privacy of patient health information.[1]	The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of students' personal records.[2]
Who is subject to the law?	"Covered entities" and at times those who contract with covered entities.[3]	"Educational agencies or institutions" and at times those who act as an agent of an educational agency.[4]
What information is covered?	"Protected health information" (PHI) - individually identifiable health information in any form, including oral communications as well as written or electronically transmitted information.[5]	"Education records" - records, files, documents, or other materials that contain information directly related to a student and are maintained by an educational agency or institution, or a person acting for such agency or institution.[6] This includes health information in an education record.
What information is not subject to this law?	Examples include: • De-identified health information.[7] • Health information held in an "education record" subject to FERPA.[8]	Examples include: • Communications that are not recorded in any form, such as the contents of a conversation between a teacher and student in a hallway.[9] • Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.[10] • Treatment records of a student 18 and older when used only in connection with treatment.[11]
Does the law usually require a signed release to disclose protected information?	Yes.[12]	Yes.[13]
Who signs an authorization to release a minor's information?	A parent, guardian or other person with authority under the law to make health decisions for an unemancipated minor signs in most cases.[14]	In most cases, a parent[15] must sign that release. FERPA defines "parent" to include "a natural parent, a guardian, or an individual acting as a parent in the absence of a parent or a guardian."
May a youth under age 18 sign a release?	Yes, in some cases a minor must sign the release.[16]	No.
Does it prescribe what the release must include to be legally valid?	Yes, but note state laws.[17]	Yes.[18]

Not legal advice. Please consult legal counsel for assistance applying and interpreting these laws.

Guiding Question or Key Aspect	HIPAA	FERPA
May an agency ever limit or withhold information from parents?	Yes. For example, if state law restricts parent access or in situations of endangerment.[19] See endnote.	Only if there is a court order or other legal document specifically revoking the right.[20]
Does the law allow disclosures without need of a signed release?	Yes. Exceptions in HIPAA allow and sometimes require disclosures without a release.[21] Some examples include: • For treatment purposes.[22] • For payment purposes.[23] • For research purposes.[24] • To comply with mandated child abuse and public health reporting requirements.[25] • Additional exceptions also exist.[26]	Yes. Exceptions allow disclosures.[27] Some examples include: • Sharing de-identified information.[28] • Sharing "directory information."[29] • Sharing with "school officials"[30] in the same educational agency who have a "legitimate educational interest" in the information[31] • Additional exceptions also exist.[32]
Does the law allow disclosures in order to prevent danger or harm?	Yes, to lessen a serious and imminent threat based on criteria in HIPAA.[33] See endnote.	Yes, in a health or safety emergency based on criteria in FERPA.[34] See endnote.
Does the law allow disclosures of health information in a file to teachers or principals without a signed release?	Not usually. There is no exception in HIPAA that generally allows health care providers to share information with school officials; however, there may be specific scenarios in which such release would be allowed under another exception, such as the "imminent threat" exception described in endnote 34.	Yes, sometimes.[35] There are several exceptions that might apply to allow such release in a given scenario, such as the "legitimate educational interest" exception described in endnote 32.
Does the law allow disclosures of health information to other health providers?	HIPAA permits health care providers to disclose protected health information to other health care providers for "treatment" purposes. HIPAA defines "treatment" broadly in this context to include coordination or management of health care, consultation and referral as well as direct treatment.[36]	No exception generally allows release of health information in an education record to health care providers; however, there may be specific scenarios in which such release would be allowed under another exception, such as the health or safety emergency exception described in endnote 35.
Effect or interaction with State law	States may have their own confidentiality laws. Covered entities must attempt to comply with both federal and state law. When state law provides greater confidentiality protection than HIPAA, providers usually must follow the state law.[37]	States may have their own confidentiality laws. Educational agencies must attempt to comply with both. To the extent that provisions of FERPA conflict with state law or regulation, FERPA usually preempts state law.[38]

Not legal advice. Please consult legal counsel for assistance applying and interpreting these laws.

Guiding Question or Key Aspect	HIPAA	FERPA
What to look for in state law	• Who has health consent rights, which in turn impacts who may sign HIPAA authorizations to release information. • Laws that describe what information parents may or may not access in their minor child's records. • Additional requirements for authorization to release forms. • Limits and clarification on exceptions.	• Local district and agency policies. • Definitions in state law or local policy that add further clarification. For example, district policy may include definitions of "school official" and "directory information" that impact application of FERPA. • Implementation policies.
Are there administrative requirements?	Yes, including but not limited to: • Notice of Privacy Practice. • Document retention requirements. • Documenting access to records. • Required forms. • Security requirements.	Yes, including but not limited to: • Annual notices of rights. • Required local policies. • Record retention rules. • Documenting access to record. • Required forms.

[1] 45 C.F.R. § 160.103.

[2] 20 U.S.C. § 1232g.

[3] HIPAA defines "covered entity" as health plans, health care clearinghouses, and health care providers who transmit health information in electronic form related to certain types of transactions. 45 C.F.R. § 160.103.

[4] "Educational agencies or institutions" are defined as institutions that provide direct instruction to students, such as schools; as well as educational agencies that direct or control schools, including school districts and state education departments. 34 C.F.R. § 99.1(a). Almost all public schools and public school districts receive some form of federal education funding and must comply with FERPA. Organizations and individuals that contract with or consult for an educational agency also may be subject to FERPA if certain conditions are met. See e.g. 34 C.F.R. § 99.31(a)(1)(i)(B)("A contractor, consultant, volunteer, or other party to whom an agency or institution has outsourced institutional services or functions may be considered a school official under this paragraph provided that the outside party-- (1) Performs an institutional service or function for which the agency or institution would otherwise use employees; (2) Is under the direct control of the agency or institution with respect to the use and maintenance of education records; and (3) Is subject to the requirements of § 99.33(a) governing the use and redisclosure of personally identifiable information from education records.").

[5] See 45 C.F.R. § 160.103 for definition of protected health information.

[6] 20 U.S.C. § 1232g (a)(4)(A)("… the term "education records" means, except as may be provided otherwise in subparagraph (B), those records, files, documents, and other materials which—(i) contain information directly related to a student; and (ii) are maintained by an educational agency or institution or by a person acting for such agency or institution.").

[7] 45 C.F.R. § 160.103.

[8] 45 C.F.R. § 164.103("Protected Health Information…Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. §1232g; ….").

[9] 20 U.S.C. § 1232g(a)(4)(A); 34 C.F.R. § 99.3.

[10] 34 C.F.R. § 99.3(b)(1)("'Education Records'… (b) The term does not include: (1) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.").

[11] 34 C.F.R. § 99.3(b)(4)("(b)The term does not include:… (4)Records on a student who is 18 years of age or older, or is attending an institution of postsecondary education, that are: (i) Made or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in his or her professional capacity or assisting in a paraprofessional capacity; (ii)Made, maintained, or used only in connection with treatment of the student; and (iii)Disclosed only to individuals providing the treatment. For the purpose of this definition, "treatment" does not include remedial educational activities or activities that are part of the program of instruction at the agency or institution").

[12] Generally, health care providers cannot disclose information protected by HIPAA without a signed authorization. 45 C.F.R. §§ 164.502(a), 164.508.

[13] 34 C.F.R. § 99.30.

[14] 45 C.F.R. §§ 164.508, 164.502(g)(1)&(3).

[15] 34 C.F.R. § 99.3("Parent means a parent of a student and includes a natural parent, a guardian, or an individual acting as a parent in the absence of a parent or a guardian.")

[16] An unemancipated minor must sign the authorization in any of the following situations: (1) the minor consented to the underlying health care, (2) the minor lawfully may obtain care without the consent of a parent or person acting in loco parentis, and the minor, a court, or another person authorized by law consented for the care, or (3) a parent, guardian or person acting in loco parentis assents to an agreement of confidentiality. 45 C.F.R. § 164.502(g)(i). Thus, who signs will depend in part on what other laws, including state law, say about when other adults may act on behalf of minors in making health decisions and when minors may obtain care on their own.

[17] 45 C.F.R. § 164.508(c). It also is important to check state law as state law may impose additional requirements for a release to be valid.

[18] 34 CFR § 99.30.

[19] When a parent consented for the child's health services, the parent, as personal representative, generally has a right to access the records unless there is a court order limiting that access. However, even where a parent otherwise has a right of access under HIPAA, there are some exceptions. For example, HIPAA defers to state law if state law limits access and HIPAA gives the health care professional discretion to withhold the child's health record in some cases, such as when the health provider in their professional judgment believes disclosure may put a patient in danger. See 45 C.F.R. §§ 164.502(g)(3)&(5) for more details. It also is important to check state law.

[20] 34 C.F.R. § 99.4.

[21] 45 C.F.R. §§ 164.506, 164.512.

[22] 45 C.F.R. §§ 164.502(a)(1)(ii), 164.506.

[23] 45 C.F.R. §§ 164.502(a)(1)(ii), 164.506.

[24] 45 C.F.R. § 164.512(i).

[25] 45 C.F.R. § 164.512(b)(1)(i)&(ii).

[26] For example, see exceptions in 45 C.F.R. §§ 164.502(a)(1), 164.512.

[27] 34 C.F.R. § 99.31.

[28] 34 C.F.R. § 99.31(b).

[29] Directory information may be shared with the public if the school and district have given public notice to parents and the opportunity to opt out. 34 C.F.R. § 99.37. The U.S. Department of Education provides a Model Notice for Directory Information, available at http://www2.ed.gov/policy/gen/guid/fpco/ferpa/mndirectoryinfo.html. The scope of the term 'directory information' will depend on district policy, but can include the following: the student's name, address, telephone listing, date and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, degrees and awards received, and the most recent previous educational agency or institution attended by the student. 20 U.S.C. § 1232g(a)(5)(A).

[30] The term "school official" includes school staff, such as teachers, counselors, and school nurses. A school or district may define this term more broadly in its School Board Policies so that it also includes outside consultants, contractors or volunteers to whom a school has outsourced a school function if certain conditions are met. See 34 C.F.R. § 99.31(a)(1)(i).

[31] 20 U.S.C. § 1232g (b)(1); 34 C.F.R. § 99.31(a)(1)(i)(A).

[32] See 34 C.F.R § 99.31.

[33] HIPAA says that a provider may disclose information, consistent with applicable law and ethical principles, if the provider in good faith believes the disclosure:
(1)   is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and
(2)   is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
There is a presumption that a provider acted in good faith in making such a disclosure if the provider's belief is based on actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority. 45 CFR § 164.512(j)(1), (4). It is important to assess whether any state law applies in these situations as well, and if so, how it intersects with HIPAA.

[34] 34 C.F.R §§ 99.31(a)(10), 99.36. FERPA authorizes disclosures to "appropriate parties" in response to a specific situation that poses an imminent danger. The release may occur "if the agency or institution determines, on a case-by-case basis, that a specific situation presents imminent danger or threat to students or other members of the community, or requires an immediate need for information in order to avert or diffuse serious threats to the safety or health of a student or other individuals." 34 C.F.R. § 99.36; U.S. Dept. of Educ. Family Compliance Policy Office, Letter to University of New Mexico re: Applicability of FERPA to Health and Other State Reporting Requirements, Nov. 29, 2004, available at http://www.ed.gov/policy/gen/guid/fpco/ferpa/library/baiseunmslc.html; U.S. Dept. of Educ., Family Policy Compliance Office, "Letter to Ms. Martha Holloway, Alabama Dept. of Educ.", Feb. 25, 2004.

[35] While FERPA typically requires a signed release, an exception allows school staff to share information with "school officials" in the same educational agency who have a "legitimate educational interest" in the information. The term "school official" includes school staff, such as teachers, counselors, and school nurses. A school or district may define this term more broadly in its school policies so that it also includes outside consultants, contractors or volunteers to whom a school has outsourced a school function if certain conditions are met. The school official must have a "legitimate educational interest" in the information. This has been defined to mean that the school official needs the information to perform his or her official duties. 20 U.S.C. § 1232g (b)(1); 34 C.F.R. § 99.31(a)(1)(i)(A).

[36] 45 C.F.R. § 164.501.

[37] 45 C.F.R. §§ 160.203, 164.202.

[38] If an educational agency believes there is an actual conflict between obligations under state law and its ability to comply with FERPA, the educational agency must notify the U.S. Department of Education's Family Policy Compliance Office. 34 C.F.R. § 99.61.

REFERENCES

1. Serious Emotional Disturbance and Functional Impairment definition from the Children's Mental Health Bu-reau Medicaid Services Provider Manual, August 2016. https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/provi-dermanuals/CMHBMedicaidServicesProviderManualAug16FINAL.pdf

2. "Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support." Barret, Eber and Weist.

3. Chapter 1 "An introduction to the Interconnected Systems Framework". Eber, Weist and Barrett. From Advanc-ing education effectiveness: Interconnecting school mental health and school-wide positive behavior support

4. IBID

5. Chapter 2 "Considerations for School Mental Health Implementation Framework." Sugai and Stephan. From Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support

6. IBID

7. Restori, A. F., Gersham, F. M., Chang, T. (2007). "Functional assessment-based interventions for children at-risk for emotional and behavioral disorders." The California School Psychologist. Volume 12(9). p. 9-30.

8. www.pbis.org

9. https://www.pbis.org/school/tier-3-supports/what-are-school-level-tier-3-system

10. Pinkelman, S.E. and Horner, R. H. (2017) "Improving implementation of function-based interventions: Self-monitoring, data collection, and data review." Journal of Positive Behavior Interventions.

11. Restori, A. F., Gersham, F. M., Chang, T. (2007). "Functional assessment-based interventions for children at-risk for emotional and behavioral disorders." The California School Psychologist. Volume 12(9). p. 9-30.

12. Fallon, L. M., O'Keeffe, B.V., Sugai, G. (2012). "Consideration of culture and context in school-wide positive behavior support: A review of the current literature." Journal of Positive Behavior Interventions. Volume 14(4). p. 209-219.

13. Pinkelman, S.E. and Horner, R. H. (2017) "Improving implementation of function-based interventions: Self-monitoring, data collection, and data review." Journal of Positive Behavior Interventions.

14. Stormont, M., Reinke, W. M., Newcomer, L., Marchese, D., Lewis, C. (2015). "Coaching teachers' use of social behavior interventions to improve children's outcomes: A review of the literature." Journal of Positive Behavior Inter-ventions. Volume 17(2). p. 69-82

15. https://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=205

16. National Survey of Children's Health. July 2014 and Trauma Informed Approaches: Opportunities and Chal-lenges in Montana. http://www.mthcf.org/2017/01/trauma-informed-approaches/

17. Trauma Informed Approaches: Opportunities and Challenges in Montana. http://www.mthcf.org/2017/01/trauma-informed-approaches/

18. https://www.samhsa.gov/nctic/trauma-interventions

19. http://www.elevatemontana.org/wp-content/uploads/2015/12/ACE-Master-Trainers-BIOS-PHOTOS-123115.pdf

20. "Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support." Barret, Eber and Weist.

21. Data received from personal communication with OPI Analysts, January 2018

22. https://www.pbis.org/Common/Cms/files/pbisresources/SWPBIS%20Tiered%20Fidelity%20Inventory%20%28TFI%29.pdfhttps://www.pbis.org/Common/Cms/files/pbisresources/SWPBIS%20Tiered%20Fidelity%20Inven-tory%20%28TFI%29.pdf

23. https://www.pbisapps.org/Resources/.../Self-Assessment%20Survey.rtf

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